JULY/AUGUST 2013

REGISTERED NURSE JOURNAL

On second thought…

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Summer story collection • Innovations in mentorship • Notice of 2014 AGM

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The Nursing Education Initiative (NEI) is a program funded by the Ontario Ministry of Health and Long-Term Care to provide nurses (RNs and RPNs) practising in Ontario with funding for professional development.

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- Les critères de sélection
- Le processus de demande
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As of August 1, 2013, **RNs must complete their applications online**. See http://www.RNAO.ca/NEI for details.

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Ontario

www.RPNAO.org

www.RNAO.ca/NEI

RPNAO
Registered Practical Nurses Association of Ontario

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

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COVER PHOTO: ROB WAYMEN

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EDITOR'S NOTE KIMBERLEY KEARSEY

With reflection–and laughter–we grow

In June, I had the opportunity to travel to Halifax to attend the conference at which *Registered Nurse Journal* was recognized with a national award. I was thrilled to be there in person to accept our first-place prize from the Health Care Public Relations Association. Many entries arrive each year for this competition to honour excellence in health-care work behind the scenes, and the editorial team is proud of its win in the external publications category.

As we celebrate this achievement, we are mindful that we cannot rest on our laurels, and must always strive to improve. Beginning this summer, we are asking readers to take a few moments to complete an electronic survey, providing feedback that will help us to identify what you like most about your magazine, and where we can make changes that will improve your reading experience. We encourage you to browse the digital versions of RNJ, and to select the link that will allow you to share your insights and suggestions (www.RNAO.ca/resources/rnj).

In the magazine world, it's easy to get stuck in the status quo, and to only realize once you've stepped away that there is excitement and innovation in change. That is just as true for the nurses we profile in this particular issue: nurses who stepped out of their comfort zones in different professions to begin the journey to become RNs (page 12). Their experiences and motivations may remind you why you chose the profession, and what you love most about it.

Also in this issue, we bring you our annual collection of stories written by – and for – members (page 18). This year, you've shared some of your funniest nursing moments, and we hope these comical scenes bring readers back to a particularly poignant or memorable moment in their own careers. These moments we take to laugh at ourselves help bring perspective to our lives, and help break some of the monotony of everyday life. Enjoy. **RN**

As a member, you are eligble to receive a sneak-peek of each and every *Registered Nurse Journal* delivered by email as the printing press hums, but before the ink dries.

If you haven't received the magazine electronically, please let us know by contacting editor@RNAO.ca

MAILBAG

RNAO WANTS TO HEAR YOUR COMMENTS AND OPINIONS ON WHAT YOU'VE READ OR WANT TO READ IN RNJ. WRITE TO US (250 WORDS MAX) AT LETTERS@RNAO.CA

Proud BPSO sees fruits of its labour

Re: Becoming a BPSO, March/April 2013

We applaud RNAO for its Best Practice Spotlight Organization (BPSO) program, and for profiling BPSOs in a variety of practice settings. Here at Grand River Hospital, we echo our colleagues' comments concerning the positive impact of best practice guideline (BPG) implementation on patient, staff and organizational outcomes. Looking ahead, NQuIRE will be an important database for organizations to measure, monitor and compare outcomes.

During our BPSO journey, we have implemented 15 BPGs and are implementing three new guidelines this year. After four years of implementing the Healthy Work Environment BPGs in several programs, we are beginning to see the fruits of our labour, evidenced by improvements in our 2013 *Staff Engagement Survey* results. We believe that BPG implementation has caused a cultural shift. Change initiatives are consistently examined through the lens of best practice at all levels of the organization.

Involvement in the BPSO program has also provided us with unlimited opportunities to share and learn from other organizations. During the past year, we have nurtured our relationship with a neighbouring BPSO, Cambridge Memorial Hospital. Quarterly meetings allow us to share successes and challenges concerning common BPGs. Last year, both organizations implemented the restraints BPG and joined forces to evaluate knowledge levels prior to and following an educational intervention. Joint events have promoted networking within and between organizations, while learning about BPG implementation and evaluation. Through the BPSO program, we will continue to explore ways to leverage each other's strengths for the benefit of our patients, staff and organizations.

Karen Cziraki, Lynne Julius, Joy Bevan, Debbie Bruder
Kitchener, Ontario

"THROUGH THE BPSO PROGRAM, WE WILL CONTINUE TO EXPLORE WAYS TO LEVERAGE EACH OTHER'S STRENGTHS FOR THE BENEFIT OF OUR PATIENTS, STAFF AND ORGANIZATIONS."

Optional CNA membership worries some

Re: President's View, Making CNA membership a choice, May/June 2013

I am very disheartened by the decision to make membership in CNA voluntary for RNAO members, and the process by which that decision was made.

RNAO made a commitment to members in 2006/2007 to maintain a strong relationship with CNA. The words of support in the president's column for a strong national nursing organization are not in alignment with the decision, in my view. When membership became "voluntary" for ONA members, RNAO took years to recuperate financially and has never come close to the previous level of membership. I would expect that RNAO would demonstrate its commitment to a strong national organization by helping CNA to navigate the upcoming challenges, not adding to them.

From my perspective, the process by which this decision was made and conveyed to members lacked professional integrity, authenticity and openness that we expect from our professional association. Given the changes at CNA are not in effect until the fall of 2014 and that CNA has offered to hold membership fees steady for two years, there is time for meaningful dialogue and input into the decision by members. I believe that together, we can come up with strategies that strengthen and protect both organizations. The choice would be more balanced if, to be an individual member of CNA, you did not need to be a member of RNAO.

I request that the board rescind the decision and broaden the dialogue with members in an open and authentic way.

Michelle Cooper
Ancaster, Ontario

I read Rhonda Seidman-Carlson's piece in the *Journal* and do not support making CNA membership optional. RNAO seems to have unilaterally decided that CNA will raise its fee due to its 'financial uncertainty' without giving CNA a chance to make its own decision about how it will address its revenue losses. This seems premature and heavy handed. At the very least, the full membership should have had the opportunity to weigh in on this important decision. I am concerned because:

1) As nurses in the most heavily populated province,

MAILBAG

we should be supporting our national association, a professional body that ensures a pan-Canadian voice for nursing.

2) This decision alienates us from CNA and may set a precedent for other provinces and territories.
3) RNs in Canada have greater influence on federal, provincial and territorial health public policy when they speak with a unified, evidence-informed voice.
4) CNA is involved in many multidisciplinary public initiatives that advance our universal health-care system and nursing practice.
5) CNA emphasizes evidence-based decisions and collaborates with researchers to generate the data to inform nursing policy and practice decisions.
6) CNA's financial viability may be seriously threatened by this decision (especially if other provinces and territories follow), and this would be truly tragic for nursing.

I am proud of both CNA's and RNAO's enormous contributions to nursing. I am profoundly disappointed with this decision, and urge you to reinstate universal membership.

Alba DiCenso
Hamilton, Ontario

Now more than ever, the Canadian public and Canadian nurses need a strong national nursing organization. In order for CNA to fulfill that role, changes to its structure are needed to prevent the regulatory mandate of other jurisdictional CNA board members from hijacking an agenda of political activism. I am optimistic that current efforts to make such changes will position CNA to become, once again, the powerful nursing voice in the national corridors of power that it was in 1984.

I am, therefore, devastated with both the direction the RNAO board has taken and the manner in which it has taken it. In a country in which democracy is diminishing daily, I did not expect my RNAO to engage in Harperish politics. With pride, I tell my students that RNAO is different from every other jurisdictional nursing organization in Canada because it is membership driven. I can no longer say this in good conscience. The decision to make CNA membership voluntary was made behind closed doors, under the premise of "policy." This implies that policy decisions are necessarily exempt from membership consultation. This is particularly puzzling given membership's clear message only a few years ago about its desire to maintain a strong and supportive relationship with CNA.

I fear that with this decision, RNAO will be the architect of CNA's destruction, rather than the pillar of strength and support it needs.

Adeline Falk-Rafael
Toronto, Ontario

RNAOnline

WHAT PEOPLE ARE SAYING ABOUT RNAO AND RNJ ONLINE.

@CindyFajardoRN: Happy Nursing Week to all nurses! Having BPSO Launch to celebrate Telehomecare in Ontario & partnership w/ @RNAO.

@SteveClarkMPP: Thanks to my Tri County Health Unit for organizing a big turnout for #NursingWeek2013 @RNAO

@OntarioShores: An enjoyable Take Your MPP to Work with @RNAO @TracyMacCharles and John O'Toole #nursingweek

Send your tweets to **@RNAO**

Former member can't recall why she let membership lapse

Re: *Registered Nurse Journal*, May-June 2013

I just read the *Journal* online and thoroughly enjoyed the articles and quality of the writing. I have not been a member of RNAO for many years, and I'm questioning why I stopped my membership. I read the digital version of the May/June edition, which a friend, who is a member, shared with me. A most interesting article was *SARS: A decade later*. It brought back many memories of our involvement at the Sudbury & District Health Unit. I was especially moved by Marie Loughnane's piece for *In the End: What Nursing Means to Me*. Tears came to my eyes as I read the article and remembered my years of bedside nursing, and how rewarding it felt to give that kind of care and compassion to a patient. I could relate to her understanding of the emotional pain that people feel when there is a drastic or gradual change to their health, and how they see themselves as a person. I will soon retire from nursing and, of course, question how I will be without the identity of being a practising nurse. Maybe the *Journal* will be my connection.

Janet Spergel
Sudbury, Ontario

Letters to the editor and opinion pieces responding to feature articles or columns must not exceed 250 words. RNAO reserves the right to edit for length.

The breadth of a board and its fiduciary responsibility

What does it mean to be a member of a board of directors (BOD)? What skills and knowledge does one need to fulfill the duties that fall under governance, the main responsibility of any BOD?

These were the questions we discussed at RNAO's BOD meeting in June. For some, it was their first meeting, and an opportunity to learn about their new responsibilities and areas of accountability. For others, it marked the beginning of their second term.

As your president, I want to tell you how proud and invigorated I feel. I am halfway through my term and I have learned so much about the association to which we proudly belong. I have learned from members and from colleagues on the board.

One thing that astounds me about RNAO is the strength of its BOD. I have been privileged to be involved for six years as a regional board member and one as president. Each board member comes to the table with tremendous commitment and personal strength, and the group grows together as individuals and collectively as board governors. BOD members cover the breadth and depth of our profession, representing all health sectors and roles. Each member brings an important perspective that enhances discussion and dialogue. And all come wanting to represent the constituency that elected them to bring their voice to the table. Each board member comes to realize there are many hats that they must wear. An important part of the learning curve is figuring out when to wear each hat.

Board members are informed by their own experiences and the issues within their region, specialty, or interest group. However, the board must function as a governance structure and make decisions that are in the best interest of RNAO as a whole.

> "One thing that astounds me about RNAO is the strength of its board of directors."

Let me share more about this role of governance.

To be strong and responsible governors, board members must meet certain responsibilities, often called *fiduciary responsibilities*. These include avoiding or declaring conflicts of interest around any issue being discussed and decided by the board. The other responsibility is to act in the best interest of the organization. This is one of the hardest tasks associated with being a board member. Each of us has personal beliefs, opinions, directions and constituents to answer to. However, when decisions need to be made, the board must ask: what is best for RNAO as a whole, even if this means facing opposition outside the board. BOD members who do not act in the best interest of the organization, and whose actions result in a negative impact on the organization, can be held legally accountable.

Recently, RNAO's board decided to make CNA membership optional for RNAO members. Beginning Nov. 1, 2014, RNAO membership and CNA membership will have separate tick-off boxes on the association's membership form. New and renewing members will have a choice to select CNA, which we will very much encourage you to do.

This decision falls under RNAO's BOD policy governance, and rests solely with the board, meaning it is assigned to board members who are held accountable for acting in the best interest of our nonprofit corporation (RNAO). It's important that everyone reading this column know that individual members are not held accountable, nor can members be held legally liable. Only members of the board, who are elected, can be legally liable. This helps explain why some decisions, including some of the difficult ones, rest with the board.

I appreciate that some members may find this distressing. I am sorry if anyone feels this way. The board acted with due diligence when it decided to make membership within CNA optional, and not to continue to offer it as an automatic benefit of membership with RNAO. It reviewed information, debated directions, clarified personal opinions, and discussed the opinions of constituents. When it came time to vote, the board voted as governors, focusing on what is best for RNAO. It passed a motion in April to change the CNA membership for RNAO members from being embedded within RNAO's overall fee, to being separate and optional. At its June meeting, the BOD also made important decisions in terms of directions for the CEO to implement this change.

This was (and is) a strong board, which consists of members who engage in vigorous debate. At times, we disagree. But past and present BODs are not influenced by fancy words, strong sentiments or positional power. Your board is focused on wanting to do what is best for the future of RNAO, our professional nursing association.

As president, I am proud to have led two distinct BODs that I believe are both courageous and made the right decisions. **RN**

Rhonda Seidman-Carlson, RN, MN, is president of RNAO.

Moving board decisions to lived realities

RNAO IS – AND ALWAYS WILL BE – membership driven. The association prides itself on its extensive engagement with members, and we rely on you to give voice to nursing in Ontario. Your elected board of directors (BOD) and RNAO staff know that you are the bloodline that makes our association one of the most vibrant in modern times.

Rhonda Seidman-Carlson, our president, explains in her column (page 7) the critical governing role of RNAO's board in setting the association's policy directions. To complement her column, I share here highlights of how BOD decisions evolve from direction to reality under my 'operational responsibility' as your chief executive officer (CEO).

This 'operational responsibility' means that it is up to me and my staff to determine how to best implement BOD directives. This includes developing the necessary programs and services, evidence-based advocacy, strategic communications, and day-to-day logistics to deliver the expected outcomes. This is how, following a BOD directive to advance primary care, we delivered the groundbreaking report, *Primary Solutions for Primary Care: Maximizing and Expanding the Role of the Primary Care Nurse in Ontario*. We received the endorsement of all political parties and major stakeholders on this work, and engaged members in effective, evidence-based political action. This culminated in an announcement at RNAO's 2013 annual general meeting, where Premier Kathleen Wynne committed to expanding the role of nurses to include RN prescribing. Although we celebrate this critical milestone, for RNAO, the job is not done. Capacity building is, for us, part and parcel of shaping and sustaining positive health system transformation. Thus, as I write this dispatch, the first ever *Primary Care Institute* is underway with resounding success.

> "KEY TO OUR COLLECTIVE IMPACT IS MEMBER ENGAGEMENT, WHICH IS CENTRAL TO OUR ABILITY TO TRANSFORM POLICY DIRECTIVES INTO CONCRETE RESULTS."

Key to our collective impact is member engagement, which is central to our ability to transform policy directives into concrete results. This engagement happens through action alerts and through events such as *Day at Queen's Park* (and this year's *Queen's Park on the Road*) or *Take Your MPP to Work*. It also happens when we ask you to speak with the media. Engaging you in the association's policy work makes it real for you and for those we want to influence. It raises awareness and affords RNAO and RNs a robust voice that is respected, trusted, and heard by politicians, the media and the public. Such a comprehensive and cohesive approach to moving our BOD's governance directions into reality is characteristic of the work RNAO staff delivers day in and day out.

Following the board's recent decision to make membership in the Canadian Nurses Association (CNA) optional, home office staff will begin giving members a choice to join CNA starting Nov. 1, 2014. Our first goal has been to keep you well-informed, and we are doing so through our monthly newsletter, *In the Loop*, webinars and an extensive *Q&A* on the website (www.RNAO.ca/news/optional-cna-membership-qa). We are also inviting RNAO members to attend a segment of the association's next assembly meeting (Sept. 28) that will be dedicated to further discussion on the transition. Anyone interested in participating should visit www.RNAO.ca for details. All you need to do is register, and come prepared. The goal is to provide more information, and to seek member input and strategies for successfully promoting membership in both RNAO and CNA.

As reiterated by our president, the dual purpose of the board's decision is to allow RNAO to remain an engaged jurisdictional member of CNA for the long haul, and to provide choice to our members. With your active and positive engagement, we will encourage all RNs in Ontario to join RNAO and all RNAO members to remain proud members of our national nursing organization. RNAO is a powerful professional association, and it's in large part due to our voluntary, not mandatory, nature. Our BOD and staff believe that if we all work together, the same will hold true for CNA.

We all want CNA to succeed, and a sure way for RNAO to help is to continue being CNA's strongest contributor on priority matters related to policy and political advocacy. As an organization, RNAO has contributed to nursing's national voice and influenced many issues. Most recently: expanding RNs' scope of practice to include prescribing; health-care access to refugees in Canada; harm reduction and safe injection sites; Canada's *Health Accord;* and the work of the Council of the Federation. We have every intention of continuing that very strong and active partnership. **RN**

DORIS GRINSPUN, RN, MSN, PhD, LLD(HON), O.ONT, IS CHIEF EXECUTIVE OFFICER OF RNAO.

Early yearnings return later in life

JUDITH GREENWOOD-SPEERS SAYS HER SWITCH TO NURSING FROM RETAIL WAS THE "BEST DECISION" SHE'S EVER MADE.

When she was in high school, two of Judith Greenwood-Speers' friends passed away. One died in a car accident; another died of leukemia. Each loss motivated her to think about becoming a physician. She also toyed with nursing and politics. Growing up with inspirational female leaders such as former Conservative MP Flora MacDonald, elected in the 70s, and Judy LaMarsh, the second woman to serve as a federal cabinet minister in 1963, fuelled the latter interest. "I felt that politicians were reachable, but I had no intention then of becoming one," says the now former Green Party deputy leader (Ontario chapter), president and inaugural advocate for health and long-term care.

Back then, health care and politics took a back seat to Greenwood-Speers' other love: business. She discovered her aptitude for retail at the age of 14, when she sold her father's excess produce on the family's Wolfe Island farm near Kingston. She graduated from high school and entered a five-year training program with a North American retailer. She worked her way through the ranks, but when a promotion required her to travel just as she began thinking about starting a family, she decided it was time to revisit those early yearnings of health care, and enrolled in nursing at Kitchener's Conestoga College.

She continued to foster an interest in politics (her elective was political science), which began at the age of 14. She was barely a teenager when she began doing her own taxes and noticed just how much money was going towards Ontario's health-care spending. "I was keenly aware that health care would always be linked to politicians and legislation, so understanding it... was an active goal."

Three things you don't know about Judith Greenwood-Speers:

1. She helped to form the Kitchener-Waterloo chapter of the Raging Grannies, a social justice and activist organization.
2. She is a Canadian history buff.
3. David Suzuki is the reason she became aware of the Green Party of Ontario's platform. He was signing books at a Waterloo store when the two started talking politics.

More than three decades later, Greenwood-Speers says becoming a nurse was "the best decision I've ever made." She worked as a staff RN at Kitchener's Grand River Hospital for 21 years, then as a nurse supervisor, executive director and director of administration at health centres in Cambridge, Parry Sound and Guelph.

By 1995, her passion for politics and discovery of the link with nursing had led to a great deal of lobbying. She wrote letters to political leaders on topics such as boosting the number of care hours in nursing homes. Caring for the elderly is her greatest boon, she says. "Helping them to live their best is a real art and science." That's why she is vocal when she sees the need for improvement in the system. In fact, she recently fired off a letter to Health Minister Deb Matthews lamenting the quality of care in long-term care homes and suggesting improvements such as staffing hours and ratio of RNs per patient.

Nurses are "the front-line, and patients count on us because we understand what they are up against in getting their needs met," she says. "Tommy Douglas' vision was right, and a lot more (attention) needs to be directed at the social determinants of health to keep health care affordable and people healthy."

Greenwood-Speers first ran for Waterloo regional council in 1997, when she became concerned about public health budget constraints. She didn't gain a seat, but the experience motivated her to stick around politically. She ran for Waterloo city council in 2000 and 2003. And, in 1999 and 2007, was the Green Party candidate for Kitchener-Waterloo. It was during that time she also assumed the roles of first deputy leader of the party's Ontario chapter, party president, and inaugural advocate for health and long-term care, a title she held for a decade.

While she enjoyed being a candidate, Greenwood-Speers is now hoping to work behind the scenes to make a difference in public policy. She knows she has a lot to offer as a nurse with over 30 years of experience.

Looking back at that uncertain teenager who flip-flopped from sales to nursing to politics, Greenwood-Speers, who is wrapping up a project management role in Kingston, admits this is not the career path she expected to follow, but is proud of the work she's done. Her decision to pursue nursing as a second career is one she's never regretted. It's helped her to sharpen her advocacy skills, she says. "Our universal health care is the thorn in the lion's paw. Understanding how it can be undermined, and how to stop it, is essential." **RN**

MELISSA DI COSTANZO IS STAFF WRITER AT RNAO

NURSING IN TH

Community outreach RN Patti Barrett-Robillard (left) shares a laugh with one of her clients at home.

PHOTO: ERROL McGIHON/QMI AGENCY

Happier at home

Patti Barrett-Robillard is a community outreach nurse with the Local Health Integration Network (LHIN) in Ottawa. The LHIN is now working with that city's Public Health Community Connect program to help link those who are isolated in their homes with the resources they need to feel supported and secure. "We want to get to them while they're healthy," says Barrett-Robillard, who acts not only as a health professional, but also a confidante and friend to many seniors who are under her care. These programs have been around for some time, she says, but now they're being expanded to reach more of Ottawa's elderly population, which is expected to double in the next 20 years. Keeping seniors in their homes means saving millions of taxpayer dollars every year, she adds. Occasionally armed with a bouquet of flowers, Barrett-Robillard's monthly home visits allow her to provide primary care and health education, which enables clients to live independently in their homes "…instead of at the hospital, because that's usually the worst outcome." (*The Chatham Daily News*, April 26)

Offering men preventive health care

Maureen Dennis urges men to take preventive health more seriously, especially when it comes to the detection of cancer. She is creator and co-ordinator of a free Men's Health Clinic held each year in June. Run by the Windsor Essex Community Health Centre for the past six years, the clinic offers: prostate, skin and colorectal cancer screening tests; medication and dietary advice; blood pressure and blood sugar tests; and testicular health awareness services to men. Dennis began thinking about setting up the clinic while working as a primary care nurse in medical oncology at the Windsor Regional Cancer Centre. Caring for cancer patients, she would often think, "why wasn't this detected earlier? You know, this could have been detected earlier and the outcome would have been so different." Dennis applied for a grant through a fundraising organization – Motorcycle Ride for Dad – which supports prostate cancer research and public awareness through a major motorcycle event in 30 Canadian cities. She was approved for funding to set up the clinic, which she deems "almost like (a) gift of health." Dennis believes that if the clinic allows for early detection of cancer in just one person, it's worth it. (*The Windsor Star*, June 17)

Northerners get health advice from a distance

In June, North East Community Care Access Centre client

E NEWS

BY CLAIRE O'KEEFFE

services manager **Nicole Jansen** spoke to *The Timmins Daily Press* about how a virtual health program – Telehomecare – has expanded across northeastern Ontario. The program (one of three in Ontario) is led by the North East LHIN and delivered by nurses. Through technology, patients convey their health information to a nurse who then provides instructions on care. The process empowers people to become active managers of their chronic conditions, Jansen says. As a manager, she delivers orientation to new Telehomecare nurses, and workshops to nurses who already practise in this area. "This program improves a patient's quality of life because he or she can better self-manage with support, education and coaching over a distance," she says. The program's expansion this summer means there are two new nurse coaches (added to the original team of three). At least 400 residents in the north are expected to be using the service by the fall. (June 14)

Calming environment quells fear, calms nerves

Mackenzie Health in Richmond Hill is home to an innovative new project created to assist victims in crisis. The organization's Domestic Abuse and Sexual Assault (DASA) Care Centre has partnered with York Regional Police to build a new "soft interview room." It is a calming, home-like, soundproof room complete with unobtrusive video recording equipment. One of only three such rooms in Ontario, it is designed to reduce the distress that an investigation can create when victims of domestic abuse, human trafficking and sexual assault are interviewed by police. **Linda Reimer**, DASA's team leader, says: "If someone has sexually assaulted you and it was a friend you thought you could trust or it's your partner... there's a shock component...It needs to be handled very delicately." The room allows police to talk to victims at the hospital following an examination and treatment. On-call RNs who have specialized training provide care to as many as 15 patients each month. Reimer believes it's a "seamless" collaboration between health-care workers and the police. "We... respect each other's roles and recognize they're different but complementary," she says. "It's all done very discreetly at the patient's pace and with their consent." When the interview room is not being used for investigations, it provides a quiet space for the emergency room's grieving families. (*Richmond Hill Liberal*, June 24)

Councilors vote 'no' to filming clients seeking treatment

Addiction doesn't discriminate. This is one of the reasons **Abe Oudshoorn**, an RN and community health specialist, spoke out against a recent recommendation made by politicians in London, Ontario. They wanted to have the region's 12 methadone-dispensing pharmacies and five clinics – which each treat at least 40 patients daily – install outdoor surveillance cameras that would keep a daily head count of patients. Oudshoorn, a faculty member for the School of Nursing at Western University, argued that installing cameras outside a clinic would deter an estimated 1,400 Londoners from getting treatment. He said people seeking methadone treatment are "at a vulnerable point in time and they're making a choice we want them to make, so we (should)...do everything we can to make that choice happen." The recommendation was made to London's municipal council community and protective services committee in late May. By mid-June, councilors voted against the proposition. (*The London Free Press*, May 29, June 11) **RN**

LETTER TO THE EDITOR

Lynn McCleary, an associate professor in the department of nursing at Brock University, wrote to the St. Catharines Standard *(June 21) in response to new legislation* – Respect for Communities Act – *tabled by then federal Health Minister Leona Aglukkaq in June. The legislation will make it more difficult to establish supervised injection sites because applicants will be required to meet onerous requirements. The* Act *also stipulates that the final decision on opening safe injection sites is left to the minister of health's discretion. To read more about this, see Policy at Work, page 30.*

As a registered nurse, I am so disappointed my government is making it more difficult for people with addictions to access effective care. The *Respect for Communities* federal legislation is disrespectful. New rules would make it almost impossible to establish new safe injection, harm reduction programs. Credible, independent research shows that this approach is safe, effective, saves lives and improves health. It's so frustrating to, on the one hand, be told by government that we as health-care providers should be providing care based on research evidence (of course we should), while at the same time having the same government nonsensically limit our ability to do so, all on the basis of misinformation and prejudice.

Lynn McCleary
St. Catharines, Ontario

Lana Ferreira

FORMER CAREER **BOOKKEEPER**

On second thought...

Registered Nurse Journal talks with three RNs who may not have immediately embarked on careers in nursing, but who are uncovering a true passion for the profession. They each offer something unique as a result of their different experiences in the workplace. And they all agree: their second career choice is their best to date. **BY MELISSA DI COSTANZO**

LANA FERREIRA

When Lana Ferreira was a little girl, she remembers listening to her babysitter talk about how much she wanted to become a nurse. Fuelled by her passion, Ferreira had the same dream. Sadly, it was a vision that remained unfulfilled for more than two decades. Beginning in high school, Ferreira encountered a number of roadblocks that prevented her from pursuing a career in nursing. She finally realized her dream in June, when she graduated from the Humber College-University of New Brunswick collaborative bachelor of nursing program. "I think there is something profoundly wonderful (about) helping people," she says, "and that's just what I want to do."

Raised in Brazil, Ferreira finished high school and was accepted to a college course similar to Ontario's registered practical nursing program. Her goal was to complete the program, and then take steps to become a registered nurse. But a few weeks before the fall term began, classes were cancelled because of a lack of funding and applicants.

Crushed, Ferreira was left to decide between her two backup career plans: teaching or accounting. She settled on the latter, thinking she'd quickly find a job that would eventually pay for her nursing education. For a year during and after college, she worked in Brazil at a small accounting/tax firm doing bookkeeping and data entry. Nursing was "still in the back of my head," she says. Then, she met and married someone who wanted to move to Canada, and everything changed.

In 1992, Ferreira arrived in Toronto's west end. To make ends meet, she worked as a restaurant dishwasher, then as a nanny. She also cleaned houses and served coffee. Soon after, she separated from her husband. A single mom, with no friends, no place of her own, and little grasp of English, Ferreira's goal of becoming an RN was relegated to the back burner, even though it "never left my thoughts," she admits.

A connection forged through one of her part-time jobs led to a filing position at an accounting firm. Ferreira did that for one year, and then found her way to a Toronto-based publishing company, where she took up a financial assistant post. She managed accounts payable and receivable, ordered supplies and managed inventory for just over 10 years. She continued to consider nursing, but began to doubt she would ever get there.

PHOTOS: ROB WAYMEN

In 2007, the company Ferreira worked for was sold to a bigger corporation. Ferreira lost her job in the shuffle and was forced to ask herself if accounting was still right for her. "I wasn't happy... and I wanted to be happy," she says.

She decided to seize the opportunity to "do what I was supposed to do 20 years ago." In her late 30s, Ferreira returned to high school to upgrade her math, English, chemistry and biology grades. She was accepted as a mature student at Toronto's Humber College, finally fulfilling her dream to become an RN.

Financially, academically and personally, she admits it has been a challenging four years. There were times she thought about tossing in the towel. She sold her car, moved to a smaller living space, took out a student loan, and raised her daughter, now 17, on her own. Sleepless nights spent studying contributed to her struggles.

Working during the day to fund her education (Ferreira helped to co-ordinate consumer shows) was equally taxing. Her family was supportive of her plan, but friends would often ask: "Why not continue with accounting?" Ferreira knew "that's not what I want to do. I still have 20 years to work, and I might as well work in something (that will make me) happy (to get) up in the morning," she says.

As an agricultural engineer in the Philippines, Celgen Yacapin craved variety and longed to interact more with people.

The challenges and range of experiences during her clinical days made day-to-day responsibilities, such as staying on top of domestic duties, tough. She wasn't the straight-A student she wanted to be, mostly because the subject matter was difficult and different from what she had learned when she was preparing to become a number-cruncher.

With the CRNE exam behind her, Ferreira can now focus on starting the career that has been decades in the making. She hopes to eventually end up in mental health, but will start working on a medical/surgical unit to build her skills.

She's not the only one excited to embark on a nursing career: her daughter, Camilla, starts the University of Ottawa's nursing program in the fall, and Ferreira couldn't be happier. "(That) passion (for) being a nurse...never went away," she says. "I always looked up to nurses, and I never gave up."

CELGEN YACAPIN

When he was eight years old, Celgen Yacapin was admitted to a hospital in the Philippines, his native country, with a second-degree burn. He'll never forget the pain, or the nurse who cared for him: she was gentle, and helped make him feel comfortable, especially during agonizing dressing changes. That interaction stayed with him, cementing in his mind the idea that "nursing provides the opportunity to make a difference in the lives of others...(and) to care for people from all walks of life." As profound as the experience was for a young boy, the thought of becoming an RN did not occur to him until much later in life.

Twenty years ago, Yacapin began his career as an agricultural engineer in his country of birth. His titles and responsibilities changed over time. He supervised workers plotting irrigation systems, conducted research at a banana plantation, sold agricultural chemicals, and was a senior agriculturalist for the provincial government for seven years, helping to plan trade shows and honouring exemplary farmers.

It was a profession Yacapin's father encouraged his eldest son to pursue. But after 12 years of working in the field, Yacapin craved variety and longed to interact with people, travel, discover different traditions, learn, and use his critical thinking skills. Harkening back to his time in hospital as a youngster, he says "the scars (on) my back...reminded me that I should give back." He began thinking about becoming an RN.

A desire to help people at all stages of life drew him to the profession and, in 2003, Yacapin enrolled in a three-year nursing degree program in the Philippines at the age of 33.

The transition from agricultural engineer to nurse was one of the steepest slopes Yacapin's ever endured, he says. He remembers sitting at his desk at the beginning of his very first class thinking "here I am in school again. Am I going to finish?" He kept his job as an agriculturalist while he studied, going to school after office hours and on weekends. He never had a day off, completing his hospital placement hours (a curriculum requirement) on Saturdays and Sundays. During this time, he also tended to his now 14-year-old daughter while his wife worked abroad.

Making the leap into the profession was a "now or never scenario...I challenged myself, and it was worth the journey. Nursing is...a never ending (learning) experience," he says.

His first position as an RN was on a medical/surgical inpatient unit at a small hospital in his homeland, a role he held for one year before he moved to Nunavut in 2008 with his family. Relocating from a tropical climate to the harsh, cold north in another country was a shock, but Yacapin insists he loves the snow. When he was younger, he always wanted to visit a place with an abundance of the white stuff. Now, he jokes "be careful what you wish for."

Yacapin was an inpatient staff RN at the Rankin Inlet Health Centre, a job he enjoyed because he learned about local customs. The little hospital in a community of less than 4,000 also meant Yacapin had more time for one-on-one interactions with patients and their families. The Inuit, he says, are warm people who maintain close-knit relationships with family members, similar to Filipino culture. He misses working with the area's elders, and is considering returning to work in Nunavut in the future as a community health nurse.

For now, Yacapin is busy realizing another dream. Last September, he and his daughter moved to Toronto. Even before he arrived in Ontario's capital, Yacapin knew he wanted to venture into emergency room nursing so he could immerse himself in the frenetic unpredictability of an ER.

Celgen Yacapin

FORMER CAREER **AGRICULTURALIST**

Trish O'Connor

FORMER CAREER **KINESIOLOGIST**

In January, he became a full-time emergency room staff nurse at the Rouge Valley Health System. He admits that caring for critically ill patients in the ER can be overwhelming. "I'm fearful of patients dying in my arms," he says, "but in an ER...you can't avoid that." With time and support from his colleagues, Yacapin has built up his confidence, and is on the road to conquering his fear. He admits he still has a lot to learn. Luckily, that's one of the reasons he chose nursing as a second career.

He plans to specialize in this role by taking courses pertaining to advanced cardiovascular life support and trauma nursing care. "I don't want my age to be a hindrance to learning something new," he says. "I don't want to stop teaching myself and furthering my nursing (knowledge)."

TRISH O'CONNOR

Fourteen years ago, then-19-year-old Trish O'Connor had no idea what she wanted to study in university. She liked athletics and anatomy, and acting on advice from her high school teachers, signed up for a bachelor of science in kinesiology degree at Sudbury's Laurentian University.

Four years later and fresh out of school, she was hired as a kinesiologist in cardiac prevention and rehabilitation at Newmarket's Southlake Regional Health Centre. Practising offsite in an outpatient program, O'Connor worked with patients who experienced heart attacks, arrhythmias or bypass surgery. She determined their exercise capabilities and mapped out personal fitness routines. She helped them understand how to eat better and manage stress, and kept an eye on their blood sugar if they had diabetes. She enjoyed dealing with clients when they were "vulnerable, but willing to get better."

O'Connor's career satisfaction was evident to at least one of her patients: a man she had helped to walk almost five kilometres following bypass surgery. "I can tell you really like what you do," he told her after reaching the milestone many of her patients aspire to. "That was the biggest compliment I could receive," she says. "I loved being part of (patients' lives) as they were travelling through their...rehab process. They were given a second chance, and I think a lot of them realized that."

After four years on the job as a kinesiologist, O'Connor was practising to full scope. She tracked blood pressure levels, monitored EKGs while patients walked on a treadmill, and designed and organized personal and group training programs. Ready for her next challenge, she contemplated a master's degree in health promotion or adult education. That's when Karen,* an RN and O'Connor's supervisor, asked if she had ever considered a career in nursing.

The seasoned kinesiologist admits that becoming an RN was something she hadn't considered. She was already familiar with the role of nurses in rehab. RNs conduct initial assessments before kinesiologists initiate patient exercise tests. The nurses in Southlake's program also teach and coach, two aspects of her own job that O'Connor found particularly rewarding.

Curious to learn more, she sat in on a class for patients and their loved ones on the emotional impact of heart disease, led by Karen. The course made her realize "nursing wasn't just about healing physical wounds, but also acknowledging the emotional and social impact of illness," she says. "It also helped me realize that nurses treat not only the patient, but the family and friends of patients."

With Karen's encouragement, O'Connor signed up for the two-year accelerated nursing degree at the University of Toronto. She quickly discovered how closely linked nursing and kinesiology are. Both promote enhanced quality of life, she says. One focus of kinesiology is physical activity, and how that helps to improve health. By contrast, nursing draws on psychological, psychosocial, emotional and social determinants, and how each of these affects an individual's health.

> **"Ultimately, whether a kinesiologist or RN, we are all health promoters."**
> —Trish O'Connor

Though thrilled to discover both professions work hand-in-hand, as a student, she questioned her future in the field. "I felt like I didn't really fit in with my peers because they...knew (the moment) they wanted to be a nurse." They talked about personal experiences with the health-care system, or family members who became RNs. O'Connor couldn't relate.

Her struggles continued as a staff nurse in cardiology, her first job out of nursing school. She felt frustrated when patients left the unit with little knowledge about next steps. "There were a lot of missed opportunities to teach people," she says, "and that discouraged me."

Less than 12 months later, O'Connor accepted a primary care opportunity at Orillia's Couchiching Family Health Team. For almost three years, she taught healthy weight management, diabetes and pre-diabetes programs, and developed an osteoporosis education course. It was a much better fit. "My whole life, people said 'you'll be a teacher like your mom,'" she says. "The defiant teenager in me said 'there's no way I'm becoming a teacher.' (Ironically) that's what I enjoy doing the most."

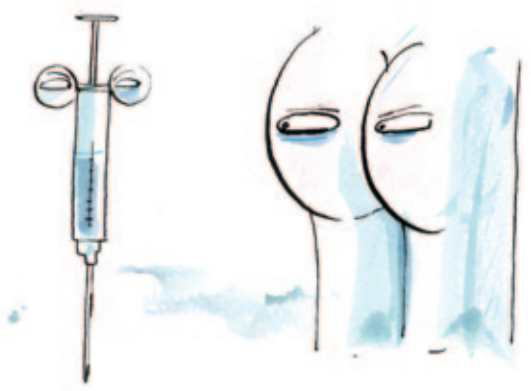
O'Connor hit her stride 18 months ago, when she took on the role of diabetes educator at the Barrie Community Health Centre. Her background in kinesiology allows her to help patients understand how physical activity impacts their disease. She likes tailoring treatment plans for her patients, and would like to incorporate more kinesiology into her role by designing exercise plans for people with target heart rates, and adapting exercises based on physical ability. "Ultimately, whether a kinesiologist or RN, we are all health promoters," she says.

Despite her rocky transition into nursing, O'Connor's current role solidifies her decision to become an RN, a move she credits to Karen. In fact, O'Connor recently called her mentor to tell her she'd be leading a session similar to the moving class she watched Karen teach eight years ago. "I questioned (going into nursing) for a number of years, but I have finally found my nursing niche," she says. **RN**

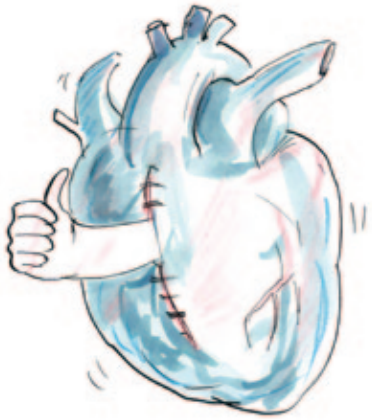
MELISSA DI COSTANZO IS STAFF WRITER AT RNAO.

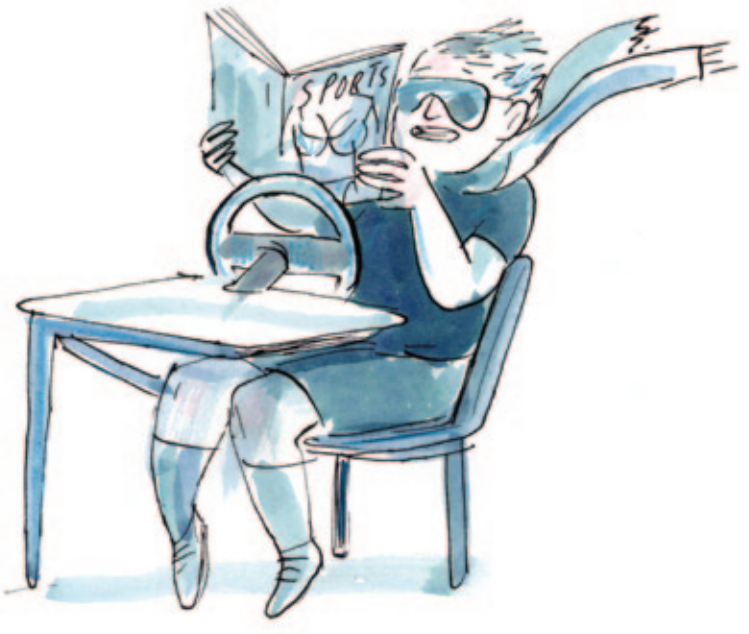
We asked some of our members who chose nursing as their second profession to tell us the top three reasons why they made the shift. Find out what they had to say at www.RNAO.ca/my2ndcareer. And write to editor@RNAO.ca if you have your own reasons for switching to nursing from another line of work.

** Pseudonyms have been used to protect privacy.*



the light side





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Each summer, RNJ features your stories. This year, we asked you to lighten the mood with a bit of humour. We wanted to hear about your funniest nursing moments in hopes that your tales would add levity to the important and often stressful work you do every day. Nurses like to laugh, and that shows in the submissions that comprise this year's collection. Thank you to all members who took the time to share their comical and lighthearted memories. We invite you to read more at www.nursingweek.RNAO.ca, and we welcome additional submissions at letters@RNAO.ca

# of nursing

ILLUSTRATIONS BY GRAHAM ROUMIEU

EDITED BY KIMBERLEY KEARSEY

the lighter side of nursing

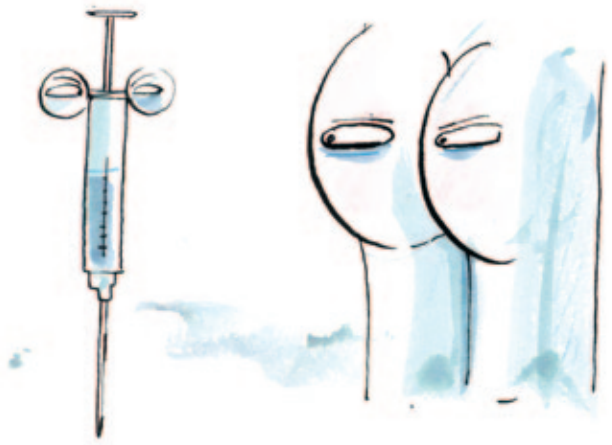
Human reproduction and 10-year-olds

The year was 1991. I had returned to university to get my BScN. I was interested in public health, and jumped into my practicum with the enthusiasm of a 20-year-old. I was actually almost twice that age, but let's not get too caught up in minor details. I had been a mental health nurse for more than a decade, so I was pretty sure I could handle just about anything. My challenge was to teach sex education to Grade 5 students. My preceptor assured me that 10 was an exciting age, and I would have a great time. I questioned her wisdom when I walked into the classroom for the first time and the teacher promptly left the room after introducing me.

I was face-to-face with a group of young people who looked at me silently for 30 seconds, then engaged in rowdy conversations with their friends while I tried to get my overheads out of my bag (it was before PowerPoint and smart boards). I managed to get their attention with bad diagrams of the naked body. Much to my surprise, they did pay attention. After a detailed, age appropriate description of human reproduction, I noticed a group of boys in the back corner of the room completely ignoring my brilliant presentation, and clearly involved in something else. When I wandered over, there was a sudden flurry of activity. But before they could cover it up, I managed to get my hands on the magazine they were engrossed in: the recently released swimsuit edition of *Sports Illustrated*. Their reactions ranged from beet-red faces of embarrassment to challenging glares.

I decided to use this as a teaching moment, even though it was a bit of a salvage operation from my perspective. I asked what they were looking at. "Women in bikinis," they said. "What's that like?" I asked, with as much casual indifference as I could muster. For the first time in the 30 minutes I had been there, it was dead silent. Finally, one brave soul piped up: "I get an ejection." I suppressed my smile and casually suggested that "an erection is a normal reaction, and happens as a result of what hormone?" Again, the terminal silence of 10-year-olds. Finally, a second brave soul offered reluctantly: "Testarossa?" He was corrected by one of his peers. "She's talking about hormones, not cars...it's testosterone!" I was so thrilled that a prepubescent boy had heard and retained something I had shared during my presentation, despite the distraction of bikini-clad women. His response left the children – and me – grinning from ear-to-ear.

Jan Slywchuk
Ailsa Craig, Ontario (Middlesex County)



Cheeky therapeutic care

Funny things happen in nursing all the time. Those of us "in the loop" can often see the humour in things that family and friends find gross or disgusting. This particular event occurred when, during my first year of nursing school at the local community college, I was on placement on a medical-surgical unit at the hospital. Those days were nerve-wracking at the best of times. I was new, innocent and mostly terrified of making a horrific mistake of some kind. Visions of causing harm or death to my poor patients ran rampant in my mind.

On this particular day, I was assigned a post-operative male patient who was probably in his mid-50s. He was brusque to the point of being rude, and spoke like a drill sergeant. He expected his every request and complaint to be handled immediately. My clinical instructor warned me of this ahead of time, but felt I was up to the task of caring for him in an acceptable manner. He advised me to be myself and just do my best. It was fine advice from someone who had half a career behind them, and had encountered any number of similar cases along the way. Personally, I was terrified. At one point in the day, my patient asked for pain medication to deal with his post-op discomfort. I visited the med room with my instructor to prepare the analgesic, and to arrange the syringe, alcohol swab, and med ticket on the small medication tray that I would take to his room.

When we arrived, he looked me and my syringe over with a disapproving frown and stated very clearly: "You can take that needle and shove it!" Without missing a beat, I replied: "Very well, roll over." After a moment of stunned silence from all of us, he complied without comment and I proceeded to inject the analgesic into his bottom – my first attempt at such an injection.

As we left the room, and were far enough down the hall to be out of earshot, I turned to my instructor expecting a lecture on therapeutic nurse-client relationships. Instead, he burst out laughing, reassuring me I had done an excellent injection and handled the patient perfectly. That patient and I got along great after that. In fact, I had him for the rest of my med-surg rotation on that unit because he asked for me by name.

Two decades later, I often think of that incident and still chuckle. Sometimes meeting a patient on their level is the best therapeutic tool there is.

Marie Salovaara
Powassan, Ontario

The difficulty with dentures

I work as a charge RN in long-term care. One day, I walked into a medical room and saw a mound of dentures on the counter. One of the unit's RPNs told me that the new resident with dementia had a habit of wandering into other residents' rooms and taking their dentures. Staff had searched her room and reclaimed the dentures that did not belong to her, hence the pile now in the med room.

The difficulty with dentures in a long-term care facility is that, once out of the mouth, they are difficult to redistribute to their rightful owner. Often, we find a stray denture lying on or under a table after a meal. Most often, these can be quickly matched to whoever was sitting at that table and is now missing their teeth. Unfortunately, in this case, most of the dentures had not been properly labeled by staff when the residents entered the facility (our policy), so returning them to the rightful owner was almost impossible.

The next day, I returned to the floor and saw a row of residents lined up at the nursing station desk. Atop the desk was a row of blue denture cups. Out of desperation, one of the new grad RPNs had lined up a group of residents at the nursing station and was trying to match the dentures to the resident by having the resident try them on. "Don't worry, I cleaned them," she assured me. Each cup held a pair of dentures that ranged from petite to large in size, varied in colour, and appeared to be in various stages of aging, just like the line of residents standing before them.

"Good luck," I said, and walked away.

Kim Epple
St. Catharines, Ontario

Dinner is served

In the late-1960s, I worked at Sensenbrenner Hospital in Kapuskasing. Shifts at the time were eight hours, and night shifts were scheduled seven in a row. While on a night rotation, my colleagues and I decided that rather than just bringing a boring sandwich for lunch at 3 a.m., we would take turns bringing a hot meal to share amongst the three of us. When it was my turn, I brought pasta. Just before 3 a.m., I turned on the hot plate to heat the sauce (this was before microwave ovens). When I turned on the second burner to cook the pasta, the fuse blew with a "poof." Who could I call in the middle of the night to change a fuse? And how would I cook pasta for my hungry colleagues? Then, it hit me. In a cupboard just outside a utility room, I found a small autoclave. I took my pot of water and pasta, placed it into the sterilizer, and set it for 20 minutes. When the buzzer sounded, I removed the pot, and "Voila!" a pot of perfect al dente pasta.

Evadne Benson
London, Ontario

the lighter side of nursing

Oops, there it is

I worked in a small community hospital from 1993-2011. I would always strive to offer the little extras that I hoped would make a difference. Whether giving back rubs or emptying urinals, there was always something to do, especially in the wee hours of the night. Plus, it was a good excuse to check on patients regularly.

During my very last night shift, I entered a dimly lit maternity ward room to refresh water and clear the bedside table for breakfast. I scooped up a few empty glass baby bottles and lids, and tossed them into the garbage cart while a new mom and her partner slept. As I turned to leave, she sprang up from an apparent dead sleep, and bellowed: "Hey, did you just throw out that lid that was on the table?"

"Um, yeah," I said. She then proceeded to tell me her newborn's umbilical cord was in the bottle lid, she was keeping it, and I'd better give it back to her. In Ojibway culture, the placenta goes back to the earth (traditionally, they hang it in a tree), and the umbilical cord is kept in a moss bag or small pouch, representing the beginning of life and the connection to Mother (Earth). I knew how important that tiny, dried up black tissue was. But how would I find it amongst last nights' Greek salad remnants, including black olives. Of course, that's all I figured was in the cap: a dried up little olive. It didn't even dawn on me it was anything else.

Panic set in. Instantly, I could feel my heart racing, my lips were dry, I was parched. My throat felt like sandpaper with every swallow. "I've got to find that bitty cord, NOW," I screamed to myself. Morning was looming, and I had other duties and patients to see. Faye, the dietary aide, would be up any minute to refresh the ward kitchen, restock supplies, collect dirty dishes, and the garbage. "I can't let her take the garbage," I said to myself. I ran to tell my colleagues what I was up against. Though there were differing opinions on the matter, I was not going to give up my search. I donned gloves and started to work quickly and meticulously. Wrappers, tetra packs, toast, gunk, salad, and so many little black olives. Is that the umbilical cord? Nope, olive.

After completely emptying out, and then rinsing the garbage bag in her bathroom sink, there was still no sign of an umbilical cord. "Did you find it yet?" she called out. "You have to find it, I need it," she demanded.

Nerves shattered and feeling the pressure, I headed back to the ward kitchen for another garbage bag, and round two. Repeat, only faster. Again, I get a sinking feeling as I come to the end. I pick up a dried piece of toast with a little black olive stuck to it. On closer inspection though, it doesn't quite feel like all the other limp, little, black olive pieces. It doesn't quite look the same colour either. Oh my God, there it is. Confirmed and returned to its rightful owner after a quick rinse under the tap.

Maryanne Carroll
Sioux Lookout, Ontario

Some comments simply defy explanation

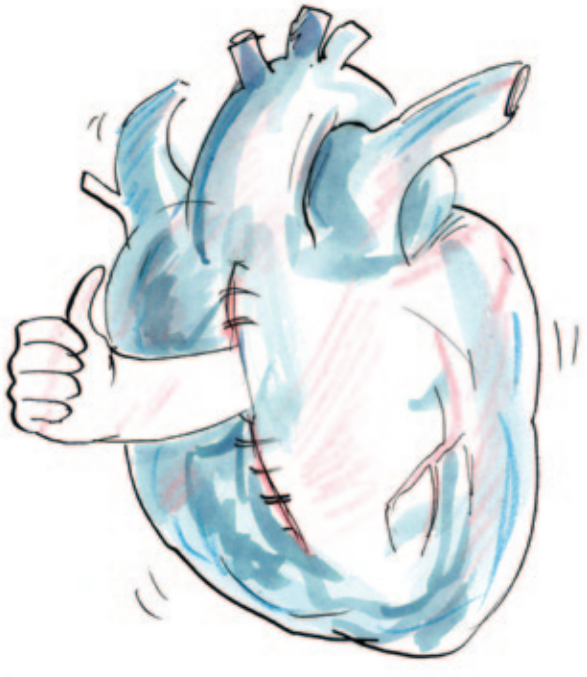
I recently picked up a quick four-hour shift on the medicine floor where I work. I did some assessments, gave out meds, and got people tucked in and ready for bed. While tending to an elderly gentleman with advanced dementia, I crouched down next to his bed and explained that I was tucking him in for a good night's sleep. He looked at me very seriously and declared: "Hail Mary full of grace, 40 chickens in a race." I roared with laughter. The memory of this random moment brings a smile to my face, and helps me to see the positive in an environment that can be exhausting and challenging.

Glennis Newton
Kingston, Ontario

No health concerns…after heart transplant

As a registered nurse on a busy surgical unit in an urban hospital, I know the early morning fast pace of admitting and preparing clients for the operating room is the norm. Once a client is changed into hospital attire, the nurse reviews the completed pre-admission assessment. This is a reasonably quick process during which current health status is assessed, and any areas of concern are quickly identified and dealt with accordingly. On this particular morning, I was caring for a young man scheduled for a routine procedure. In reviewing his pre-admission assessment, I determined he was a healthy young man based on the responses he provided in the assessment. In essence, he indicated he had no current medical issues. In conducting the review, I summarized aloud what he had written in his forms. "I see you have no heart or breathing issues, no trouble with previous anesthetics," and so on. He was proud of the fact that he was a very healthy young man. The assessment completed, I explained the procedure and obtained his consent, then escorted him to the OR waiting room. After I wished him well, I turned around and started to walk down the hall. That's when he turned to me and said reflectively, "No, I have no health concerns at all. I have been absolutely great since I had my heart transplant."

Rebecca Harbridge
Barrie, Ontario



You've got pain in your…what?

At the beginning of each night shift, I touch base with my patients to introduce myself and do a quick visual and subjective assessment. One night, I introduced myself to a patient who had hip surgery that day, and asked him how he was doing. "Not too good," he told me, noting he had lots of pain. "No hip pain, but I don't know what they did to my clitoris today in surgery, it sure hurts." I looked at him and was caught off guard by his comment. I wondered why his clitoris would hurt when he had hip surgery. The report did not tell me anything about this. I wondered if he was delusional. Is this an adverse reaction from anesthetic? Or did some instrument slip during surgery, and even though he visually appears very male, does he have female genitalia? These questions crowded my mind, but I focused my attention to assessing his pain.

I asked him what number out of 10 would he assess his pain at, and asked him to describe it. He said eight and described a constant burning. I asked him if he ever had this pain before or if he knew what might have caused it from surgery. He said, "Well, they put that tube down my throat and maybe they went too far." I was further baffled: a mouth piece certainly can't affect his clitoris, that is if he has one. I pinched myself in hopes this was one of those bizarre dreams. Unfortunately, I felt the pinch.

Suddenly, a light bulb went on in my head. Did he mean to say epiglottis instead of clitoris? Immediately, I asked him to point to his area of pain. With a fixed stare at me, he pointed to his throat. For a moment, I just stared back in amazement. I barely managed to ask him, without smiling, what he would like for pain before leaving his room. I held back my laughter until I entered the med room and burst into uncontrollable, floor-sitting laughter with my peers.

When I finally controlled myself, I took him his analgesic. "I brought you two Tylenol threes for pain in your epiglottis," I said. He looked at me, smiled, and said "yes, my epiglottis." We both smiled and said no more

Susan Hacquoil
Dryden, Ontario

Meaningful mentorship BREEDS SUCCESS

Novice RNs who are intimidated or overwhelmed starting a new career can count on innovative preceptor and orientation programs that help to ease the transition to life as a new RN.

BY MELISSA DI COSTANZO

In the fall of 2011, merely weeks after Woodstock General Hospital (WGH) staffers moved into a brand new space, administrators faced a big concern: 80 per cent of the new part-time RNs on the hospital's two acute care units were recent graduates, and 60 per cent of full-time RNs were new to the profession. These numbers made RN Jackie MacKenzie, director of acute inpatient services, panic. More beds at the new facility meant more RNs were required, but recruitment was a challenge.

Sixteen neophyte nurses "lacked the experience and the level of competency we needed," MacKenzie says. Some hadn't administered an intramuscular injection; others completed their practicums in community or public health, but had little exposure to acute care.

Given this, WGH managers decided that the hospital's traditional orientation, followed by unit-specific training, was not enough, so MacKenzie helped to devise a plan: enlist RNs and RPNs with more than five years of work experience to act as preceptors to their respective professional colleagues on the two acute care units for three months.

The idea immediately hit a barrier when some staff members said they didn't feel adequately prepared to precept. To help overcome this, would-be preceptors attended a two-hour workshop. "In next to no time, they…got into the groove," says MacKenzie.

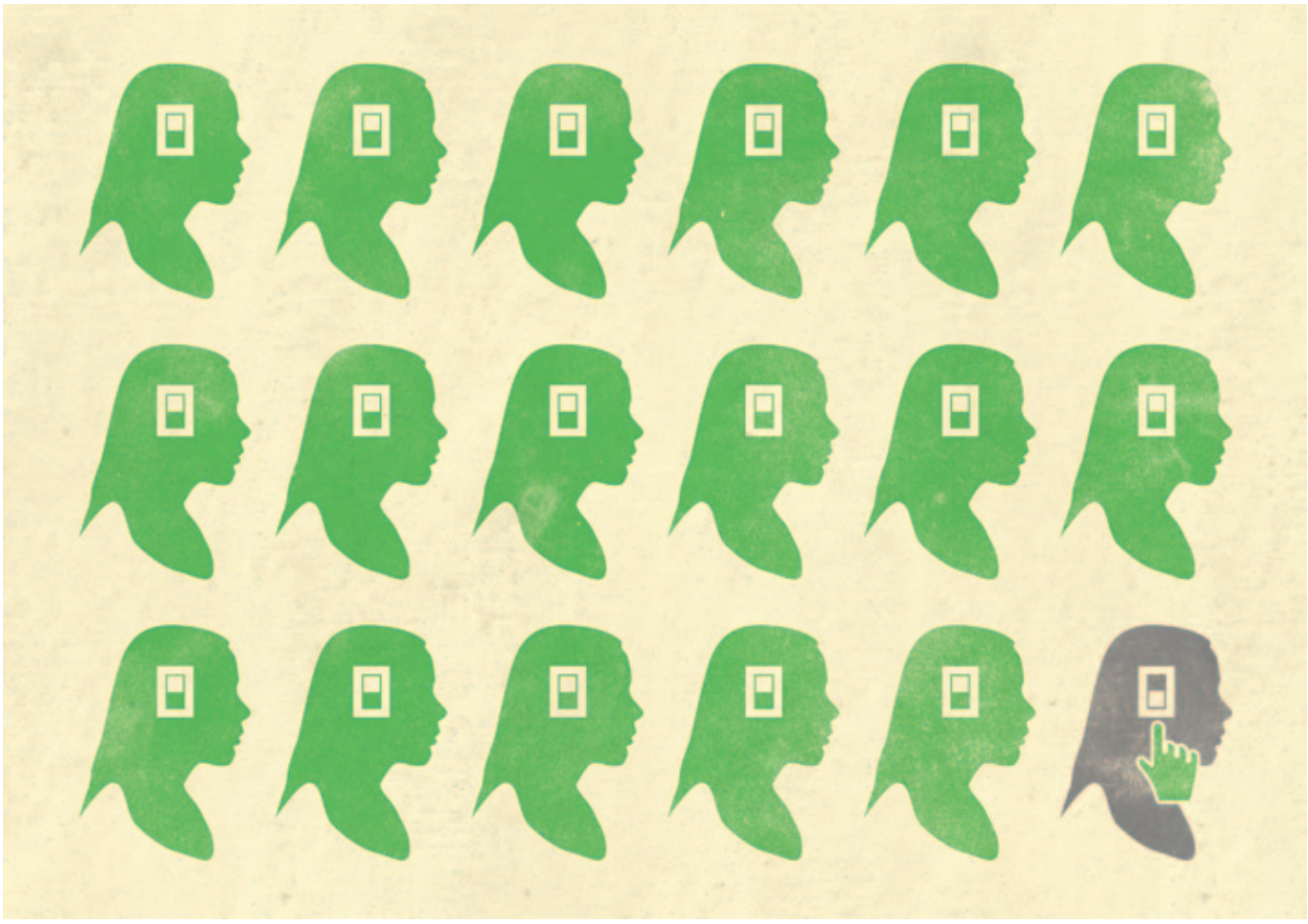
Beginning in May 2012, one preceptor led three to four new nurses during each 12-hour shift, speaking daily with the charge nurse to learn if tricky procedures, such as a central line insertion, were on the board. Preceptors (eight RNs and four RPNs) exposed the group to these experiences, in addition to standard nursing practices, such as patient assessments. Under the watchful eye of a preceptor, the new nurses participated once they felt comfortable.

If issues cropped up, nurses scribbled their comments in a logbook, monitored by charge nurses, managers and nurse educators. Managers held huddles to stay up-to-date. "We said from the outset 'we know we're doing this quickly, but we want to do it right, and we want to hear what you have to say,'" explains MacKenzie.

RN Shelley Kipp, a preceptor, appreciated the support. "This program allowed (for) more accountability," she says. "There was more follow-up (with preceptors and preceptees) to make sure (preceptees) (didn't) fall between the cracks." New nurses are now scored on their successes going through the preceptor program, whereas before, there was no way to say with any certainty how well they did during orientation.

The initiative has even prompted other hospital departments to reevaluate their orientation programs. An eight-hour education day has been added for all new staff, as well as one- to two-hour sessions to develop preceptors, and a post-orientation opportunity to examine lessons learned during the preceptor period. The project even encouraged some RPNs to sign up for BScN programs. Many emerged as strong teachers and trainers, MacKenzie says.

Patients also seemed pleased. Surveys conducted during the preceptor project indicate a post-discharge satisfaction score of 98 per cent. And although some nurses were hesitant to precept as the program got off the ground, they "saw the real benefit in making sure that our new staff were educated…they wanted them to be confident," MacKenzie says.



Meanwhile…in North York…

New RNs starting their careers at Toronto's North York General Hospital (NYGH) can also thank an innovative orientation program for easing their transition into the working world. The program is the brainchild of RN Mary Ann O'Hearne, clinical team manager for NYGH's adult mental health outpatient services, and the Emergency Psychiatric Consultation Team (EPCT). The idea for the program was born when O'Hearne noticed two RNs new to the EPCT were missing key pieces of their written patient assessments. The new RNs, whose first language was not English, were struggling to draw specific personal information out of patients.

EPCT RNs act as consultants for NYGH's mental health program, O'Hearne explains. They work autonomously in the ER, making rapid recommendations and referrals to other health-care professionals and community resources. They report to a psychiatrist, who relies on their assessments and recommendations to determine a patient's needs. Incomplete assessments can affect treatment plans.

All RNs new to EPCT shadow crisis RNs for a month to learn about the hospital's other mental health programs. O'Hearne decided the pair would spend two months with RN Fern Quint, who heads the hospital's urgent care clinic. "Exposure in the urgent care clinic made it easier to transition to the emergency department, because it's the same type of patients…at different stages of crisis," explains O'Hearne. Quint, she adds, is an empathetic nurse who spends time with the patients she assesses, making her an ideal teacher.

RNs in the urgent care clinic offer short-term crisis stabilization counseling and help patients transition to the community. Quint must conduct thorough assessments, a similar requirement of EPCT nurses.

Julia Fridmar was one of the two trainees who observed Quint with patients. She was also able to conduct her own assessments, with Quint interjecting if she thought something was missing. After the patient left the exam room, the trio talked about what went well, and areas for improvement.

Fridmar admits when she started at NYGH, she felt overwhelmed and frustrated when she could not provide proper documentation. Now, she feels confident in her ability to capture important information.

Quint also role-played with the nurses, acting as a patient to help the RNs feel comfortable with gentle probing. They prepared scripts when tackling tricky questions, such as asking a patient if they've thought of harming themselves.

Quint says it was "gratifying for me to see the nurses take a lot more pride in their own work out of the confidence that they developed." O'Hearne is thinking about providing similar support for all new hires. "I wanted to make sure I gave them everything I possibly could to be successful." **RN**

Do you have an example of an innovative mentorship/preceptorship program at your organization? We want to hear about it. Your story could be featured in a future issue of the magazine. Email editor@RNAO.ca

MELISSA DI COSTANZO IS STAFF WRITER AT RNAO.

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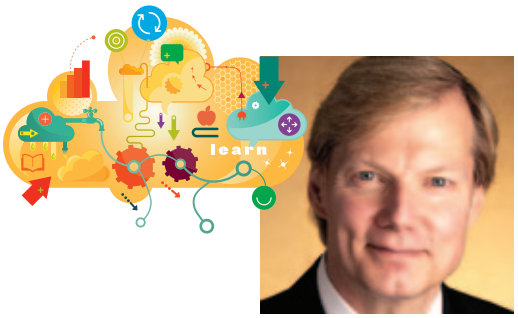

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POLICY AT WORK

Women's College Hospital NP Vanessa Wright speaks to protesters during Toronto's June 17 National Day of Action event to denounce government changes to IFHP.

A *National Day of Action* to advocate for Canada's refugees

June marked an anniversary many RNAO members would rather not celebrate. A year ago, the federal government announced a series of changes to the Interim Federal Health Program (IFHP), which provides health insurance coverage for refugees and refugee claimants. Previously, IFHP provided access to medical care, lab tests and diagnostic services. The coverage was similar to that offered by provincial health plans, including access to medication, emergency dental and vision care.

The government has effectively cut off all access to coverage for these health services as well as access to most hospital services, except in urgent circumstances. More than 1,500 members responded to action alerts (in June 2013 and May 2012) calling on Ottawa to reverse its decision. The pressure prompted Prime Minister Stephen Harper to back-track on government-sponsored refugees. However, this is not enough. Most refugees are not government sponsored, and are still suffering the consequences of the cuts. On June 17, 2013, five RNs represented RNAO at rallies organized by Canadian Doctors for Refugee Care. They spoke at events in Toronto, Guelph, Kitchener, London and Hamilton to draw public awareness to the consequences of the cuts. Health practitioners say the changes are forcing many people to wait for care until their health deteriorates. In other instances, patients who cannot pay are being denied care. Several health organizations that have continued to treat refugees have racked up huge bills by providing coverage the federal government no longer pays for. RNAO believes Ottawa's decision is ideologically driven, and is meant to deter refugees from coming to Canada. The change is unfair and unethical, and RNAO says it violates fundamental human rights.

Support for safe injection services

New federal legislation could prevent the development of more safe injection services (SIS), a move that has left RNAO gravely concerned.

Bill C-65, introduced in June, proposes tough requirements intended to thwart implementation of SIS. The bill conflicts with research that finds this type of harm reduction service prevents needless death, improves health outcomes, and contributes to safer communities. Toronto Public Health has recommended SIS implementation, and RNAO proudly supported its recommendation at a meeting of the Toronto Board of Health on July 10. The association also participated in a *Toronto Drug Strategy Implementation Panel* working group that released an SIS toolkit. Links to this, and to an open letter to politicians to provide funds to integrate SIS programs within existing clinical health services, and to denounce Ottawa's proposed legislation, are available at www.RNAO.ca/SIS

In 2011, RNAO, the Canadian Nurses Association, and the Association of Registered Nurses of British Columbia formed a coalition and were granted intervener status before the Supreme Court of Canada when the federal government attempted to close Insite, Vancouver's safe injection facility. The country's highest court voted unanimously to allow Insite to stay open.

Paying for plasma

RNAO was one of several signatories on an open letter to now former federal Health Minister Leona Aglukkaq in April regarding paid blood donors. The group questions Ottawa's decision to consider allowing a private company to get into the blood plasma business. Canadian Plasma Resources has applied for a license to operate locations in Hamilton and Toronto. RNAO joins others in criticizing a hastily organized meeting deemed a consultation with "stakeholders." The signatories want to see a more open and transparent consultation process.

Concern about the safety of the blood supply goes back 30 years when thousands of Canadians became infected with HIV and hepatitis C due to blood and plasma that was improperly screened from paid donors in the U.S. and Haiti. The scandal led to the creation of Canadian Blood Services, and also resulted in the Krever Commission, which recommended blood donors not be paid for their donations. Alberta and Ontario are not supportive of paid blood donations. And Quebec does not allow blood donors to be compensated by law. Only one company, based in Winnipeg, is allowed to engage in the private collection of blood plasma. **RN**

Hilton Toronto

NOTICE OF 2014 AGM

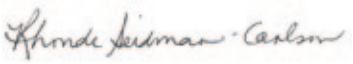
Friday, May 2, 2014

Take notice that an annual general meeting ('AGM') of the Registered Nurses' Association of Ontario (hereinafter referred to as 'association') will be held at the Hilton Toronto hotel commencing the evening of Thursday, May 1 for the following purposes:

- To hold elections of directors as provided for in the bylaws of the association *(for process of elections, see below*)*
- To appoint auditors
- To consider such further and other business as may properly come before annual and general meetings, or any adjournment or adjournments thereof

**The chair of the AGM directs that voting for the AGM shall be by electronic means, during April 2014. Results will be reported at the AGM.*

By order of RNAO Board of Directors



Rhonda Seidman-Carlson, RN, MN
President

CALL FOR NOMINATIONS 2014–2016 RNAO BOARD OF DIRECTORS

DEADLINE: Monday, December 16, 2013 at 1700 hours (5:00 p.m.)

As your professional association, RNAO is committed to speaking out for nursing, speaking out for health. **YOUR** talent, expertise and activism are vital to our success. RNAO is seeking nominees for the term 2014-2016 for:

- **4 members-at-large** (nursing education / nursing practice / nursing research / socio-political affairs)
- **Representative** of the Provincial Interest Group Chairs*

** In accordance with RNAO policy 8.06 (1), "The Provincial Interest Group Chairs shall elect a representative" [to the Board of Directors]. Policy 8.06(2) states, "The representative of the Provincial Interest Group Chairs shall be a current or immediate past Provincial Interest Group Chair."*

Being a member of RNAO has provided you with opportunities to influence provincial, national and international nursing and health-care policy, to discuss and share common challenges related to nursing, nurses, health care, social and environmental issues, and to network with numerous health professionals dedicated to improving the health and well-being of all Ontarians. Becoming a **member of the RNAO Board of Directors** will provide you with a rewarding and energizing experience. Over the course of two years, you will contribute to shaping the present and future of RNAO. You will also act as a professional resource to your constituency. To access the nomination form, visit www.RNAO.ca. For further information, contact **Penny Lamanna**, RNAO board affairs co-ordinator, at plamanna@RNAO.ca

In accordance with 2013 RNAO policies 6.02 and 6.07, members of the following **RNAO board committees** shall be appointed by the Board of Directors. Nominees are sought for the following vacancies:

- Provincial Nominations Committee
- Provincial Resolutions Committee

CALL FOR RESOLUTIONS

DEADLINE: Monday, December 30, 2013 at 1700 hours (5:00 p.m.)

Do you want to help shape nursing and health care? As a member of your professional association, you can put forward resolutions for discussion at the AGM, which takes place on Friday, May 2, 2014. By submitting resolutions, you are giving RNAO a mandate to speak on behalf of all its members. It is important to bring forward the many pressing nursing, health and social issues that affect nurses and the public. RNAO members represent many facets of nursing within the health system. You play a vital role in ensuring nurses' voices are heard, and in advancing healthy public policy across the province and elsewhere. RNAO encourages individual members, chapters, regions without chapters and interest groups to **submit resolutions for acceptance at the 2014 AGM**. Please send enquiries or materials to Penny Lamanna (see above)

Important to note:

- the resolution must bear the signature(s) of RNAO member(s) in good standing for 2014
- a one-page maximum backgrounder must accompany each resolution (this one page will INCLUDE any references) and the font used must be no smaller than Arial 10 or Times New Roman 11. Margins on this one page must also be reasonable, e.g. an absolute minimum of 0.7 margin all around
- resolutions should include support/endorsement from a chapter executive member (thus demonstrating they have knowledge of the resolution)
- all resolutions will be reviewed by the RNAO Provincial Resolutions Committee

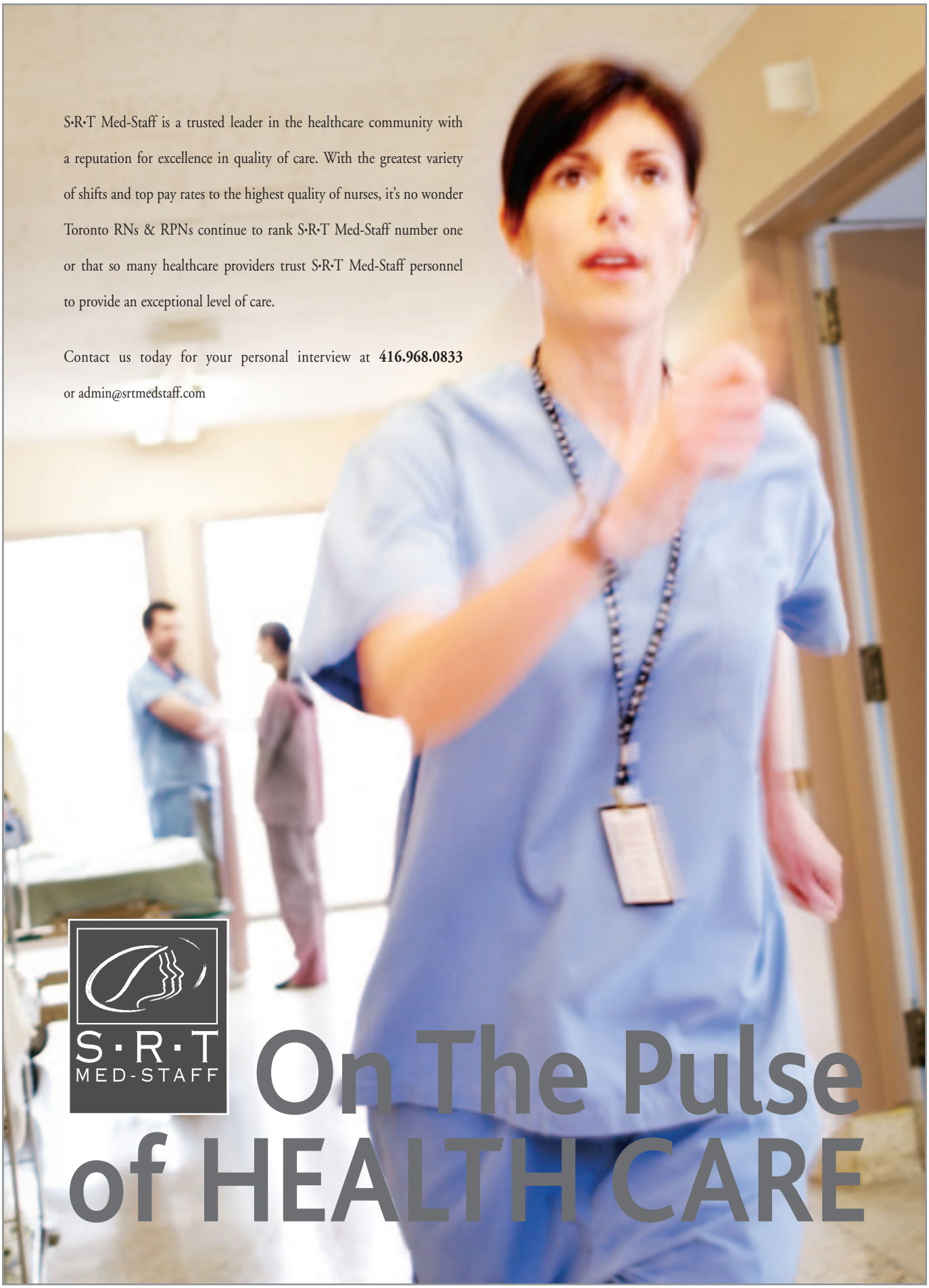
For clarity of purpose and precision in the wording of your resolution, we recommend that each resolution include no more than three 'Whereas'; and preferably only one, but never more than two, 'Therefore Be It Resolved.' Please refer to the following successful 2013 resolution for guidance:

WHEREAS suicide is the leading cause of injury-related fatalities in Canada (Mental Health Commission of Canada 2012) and accounts for 24 per cent of all deaths of 15- to 24-year-olds in Canada (MOHLTC, 2011); and

WHEREAS prevention of suicide involves identification of at-risk youth before suicidal behavior emerges; and

WHEREAS suicide is a mental health issue (MHCC, 2012 and Anderssen, 2011) that requires youth-specific prevention strategies as none currently exist in the province of Ontario; (Globe & Mail, 2011);

THEREFORE BE IT RESOLVED that RNAO develop strategic partnerships with locally relevant and collaborative partners across sectors to call for an integrated strategy to address adolescent suicide that includes: prevention, recognition/diagnosis, evidenced-based interventions, and appropriate support services for youth and families, and is inclusive of those at highest risk who are often marginalized.



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