JULY/AUGUST 2014

REGISTERED NURSE JOURNAL

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VOL. 26, NO. 4, JULY/AUGUST 2014

REGISTERED NURSE JOURNAL

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EDITOR'S NOTE KIMBERLEY KEARSEY

Fruitful revelations

Roaming the produce section at the grocery store is one of my favourite activities when it comes time to restock my fridge. Unlike most people, I actually like grocery shopping because it's a chance to clear my head. But, as head clearing goes, I don't do a whole lot of thinking, especially about the fact that those neatly lined rows of green, red, yellow and orange once hung from trees or hid under the ground.

Indeed, most of the fruits and veggies that end up in grocery carts or picked up at local farmers' markets were hand-picked by migrant farm workers like Felix (cover and page 12), who work under Ontario's hot summer sun harvesting the crops people feed to their families. In this issue, we bring you their stories, and introduce you to nurses who are helping them to access much-needed health care and personal support far from home.

NP Lydia Rybenko is one of those nurses. She and Luz Ofelia Maya, a new settlement worker from Colombia, host clinics for farm workers in Cobourg. And their story of collaboration is just one of the many we feature in this issue.

Our annual story collection from members (page 18) also focuses on interprofessional collaborations, and how they make a difference to patients. We love to call on members to share their experiences because we know there are so many great stories to tell. Your passion for patients, and getting them what they need, is always embedded in the anecdotes you share so generously with our readers.

That same generosity is demonstrated in the work you do outside of your "day jobs," specifically in relation to the resolutions you bring to RNAO's annual general meeting. These resolutions reflect the issues that are important to all Ontario nurses, and they're the focus of our feature on page 23. RNAO would not have the influence it does today if it wasn't for your initiative bringing these issues forward for discussion.

Please keep your stories – and resolutions – coming. **RN**

As a member, you are eligible to receive a digital copy of *Registered Nurse Journal*. You can choose to receive only an electronic version of the magazine by emailing info@RNAO.ca and stating your preference for a paperless version. If you haven't received the magazine electronically, please let us know by contacting editor@RNAO.ca

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An activist agenda for an evidence-based organization

My first few months as president have filled me with pride witnessing the tremendous energy, influence and impact RNAO had during the provincial election. Thanks to our association, candidates from the major political parties got a glimpse of the opportunities and challenges facing our health system, the health of Ontarians, as well as RNs and NPs on the frontlines of care. They also heard about the aspirations and expectations of nursing students as they prepare for their careers.

The strategic involvement of RNAO during the election was impressive, with activities directed by home office demonstrating what a well-oiled machine our nursing association is, fully involving us, whether senior RNAO officials or individual members across the province.

Here are some examples:

- Our annual *Take Your MPP to Work* event (normally held during Nursing Week) was re-branded to include candidates from the four major political parties. Fifty-three visits took place in ridings and workplaces across Ontario, providing a meaningful opportunity for dialogue and debate, as well as for showcasing RNs, NPs and nursing students.

- A questionnaire outlining key issues related to RNAO's vision were sent to the leaders of the Liberal, PC, NDP and Green parties. Results were posted on our website on a first come, first served basis. The questions and responses informed nurses and the public about where political leaders stood on critical issues affecting health, health care and nursing.

- Home office continued its tradition of analysing the platforms of the four main political parties against RNAO's "asks." This way nurses and others could make their own judgements regarding which party aligned best with RNAO's top priorities, including social and environmental determinants of health, Medicare and nursing.

- RNAO officials attended invitation-only announcements by Premier Kathleen Wynne and then PC Leader Tim Hudak, and were delighted to host the premier during RNAO's Career Expo, where she announced that her government would ensure RNs would be able to prescribe and that NPs would be able to order MRIs and CT scans.

- Several chapters organized or participated in debates and all-candidate sessions, including: the Kawartha-Victoria chapter, which pulled together one event in Peterborough and one in Lindsay; the Middlesex Elgin chapter, which partnered with London Health Coalition to host a debate in London; and the Windsor-Essex chapter, which hosted its *Politics and Pancakes All-Party Breakfast*, an event at which I was delighted to provide opening remarks. Region 9 board member Denise Wood was invited to ask questions on behalf of RNAO at an all-candidate debate in Kingston, organized by the Kingston Health Coalition and the Faith and Justice Coalition. It takes a lot of planning to organize these events and I thank members for their outstanding efforts while balancing work and family life.

- RNAO received excellent media coverage of its various election-related events and initiatives, ensuring health was a topic of discussion during the election campaign. In a joint media release with the Ontario Medical Association, we urged all political leaders to engage in meaningful dialogue about health care.

> "THE STRATEGIC INVOLVEMENT OF RNAO DURING THE ELECTION WAS IMPRESSIVE, WITH ACTIVITIES DIRECTED BY HOME OFFICE DEMONSTRATING WHAT A WELL-OILED MACHINE OUR NURSING ASSOCIATION IS."

Even though the election is over, RNAO's work is far from done. The top item on our policy agenda is to ensure the re-elected Liberal government moves quickly on RN prescribing and the ability of NPs to order MRIs and CT scans which will improve timely access. We will also insist on putting an end to the practice of medical tourism in Ontario (see *CEO Dispatch, pg. 6, May/June 2014*).

Together, we will urge more action on the government's toxics reduction strategy, and we will hold the government to its promise to provide meaningful anti-poverty policies. We will also continue to pursue RNAO's ECCO model, a system transformation that strengthens public health and home care, and places primary care as the anchor of all health services.

We will do all of this and more because RNAO is a force to be reckoned with, and because we care about the collective good of nurses and the people we serve. **RN**

VANESSA BURKOSKI, RN, BScN, MScN, DHA, IS PRESIDENT OF RNAO.

RNAO members have a choice to join CNA

When my membership rolls over at the end of October this year, I will be joining CNA. Will you?

Beginning this November, membership in our national nursing association will no longer be automatically renewed with your RNAO membership (see page 27 for more on this). Our board of directors made the decision in the spring of 2013 to unbundle the CNA/RNAO fees, and to make it optional for members to join our national organization.

The notion of individual choice has always been a basic tenet of RNAO membership. You can choose to join RNAO, you can choose to join interest groups, and you can choose to join the Legal Assistance Program (LAP). Now, you can choose to join CNA, and I encourage you to do so.

Choosing CNA does not increase your fees from the year before. Remember, at the 2014 annual general meeting, members approved a board motion to decrease the RNAO membership fees by the amount of the CNA fee ($62.09). Thus, when you now choose to join CNA and pay the optional fee as part of your membership registration, you will pay the same fee as the previous year.

The status of RNAO as a proud jurisdictional member of CNA remains the same. RNAO's president, Vanessa Burkoski, will continue to represent RNAO at the national table. And, RNAO's contributions to policy and advocacy work will remain as robust as ever. That's because we need a powerful voice for Canada's registered nurses.

I am joining CNA because I want to actively influence the future of our national association. I want to have a strong CNA that tackles the serious national issues confronting our country and its people. I want to have a CNA that is relevant, powerful and courageous. And I want to actively contribute to making it happen.

> "I hope all RNs, NPs and nursing students in Ontario join RNAO. And, I hope that all choose to check that box beside CNA this fall."

This fall, you will be asked to make this important choice – a choice RNAO, in partnership with CNA, will continue to promote. Like me, RNAO's president and members of our board of directors will continue their memberships in CNA because we all know how important it is for nurses to come together as one unified national voice rather than a collection of disparate voices in individual provinces and territories.

Some of the important work that our national association will focus on this year is a new strategic plan that will set the stage for areas of focus and development for the next four years. In addition, the CNA board will consider the three resolutions RNAO brought forward to the CNA annual meeting in Winnipeg in June. These resolutions, which were passed almost unanimously by jurisdictional voting delegates, focus on the need to: end medical tourism in this country; stop for-profit plasma collection; and safeguard Canada's electoral process by recognizing the federal government's recent changes to our electoral system will have far-reaching implications on already marginalized populations.

CNA will also consider six other resolutions passed in June that we fully support, and to which we will gladly contribute RNAO's expert policy analysis and evidence-based advocacy. Four of these focus on critical aspects of health, equity and justice for Aboriginal People. Another recognizes the need for a public pharmacare program that ensures all Canadians have equitable access to necessary medications. And the last one calls for an action plan to increase awareness and engagement of our direct care and specialty nurses to our provincial, territorial and national associations.

RNAO's membership fee structure has changed, but not our relationship with CNA. We will remain as strong as ever working with CNA in all areas of common interest. In our ongoing dialogue with CNA, one thing has become very clear: both RNAO and CNA want to work closely together. We want to partner for strength.

Remember: choice empowers us. Through choice, we assume responsibility as individuals and as associations. And there's nothing more powerful than thousands of RNs, NPs and nursing students choosing to support and engage in their provincial and national associations. That's very powerful, and it's very important.

I hope all RNs, NPs and nursing students in Ontario join RNAO. And, I hope that all choose to check that box beside CNA this fall. We know we can continue to count on you to work side-by-side with us, making RNAO even stronger. And, together with colleagues from across the country, we can help to make our national association stronger than ever. **RN**

Doris Grinspun, RN, MSN, PhD, LLD (Hon), O.Ont, is chief executive officer of RNAO.

MAILBAG

RNAO WANTS YOUR COMMENTS ON WHAT YOU'VE READ IN RNJ. WRITE TO LETTERS@RNAO.CA

More "real" dialogue needed on euthanasia

Re: Annual gathering manages levity amid lively – and heated – discussion, May/June 2014

It is very disappointing to see the resolution (# 1) on promoting "discussion" on euthanasia passed. RNAO has not considered the recommendations of the assembly during its meeting in February. No consultation really took place because we were not allowed to discuss the background paper that was created for the assembly meeting. If we are to "continue dialogue," we need to have more "real" discussions in order to call that a dialogue. Neither ethicists, palliative care specialists, nor the Palliative Care Nurses Interest Group (PCNIG) were consulted, and nothing about this resolution was reported to the assembly. Not assessing clients properly when they are suffering, and not responding to a desire to be comfortable, but instead offering euthanasia as a solution, goes against my belief as a nurse and as a human being.

Living in dignity requires more than euthanasia. Appropriate nursing and palliative care have not even been considered, such as pain and symptom control as indicated in our own BPG (*End-of-life care during the last days and hours*). Not doing this reflects poor quality of care. Also, it goes against good common sense not to promote RNAO's BPG, and not respecting the College of Nurses of Ontario's position on this. I do not understand where euthanasia or assisted suicide fit in with RNAO's mandate.

Paul-André Gauthier
Sudbury, Ontario

Publisher's Note

The resolution (#1), which passed by a large majority at the 2014 annual general meeting, urges a formal public dialogue on end-of-life issues and dying with dignity. The resolution does not take a position on euthanasia or assisted suicide.

Recent grad challenges evidence in safe sleep BPG

Re: A safer sleep, May/June 2014

As a recent University of Toronto nursing graduate with a long-standing interest in maternal/infant health, I eagerly read the most current issue. While the 2013 safe infant sleep BPG does an admirable job at distilling the evidence on a decidedly complex topic, I am left with three areas of concern.

The practice of swaddling is highlighted as a SIDS risk based on one study in which 19 of 78 infants who died of SIDS were reported to have been swaddled. More importantly, this study does not appear to have controlled for postpartum maternal smoking. This is a significant shortcoming and one that I would have hoped would have been addressed during the BPG's development. Given the scarcity of literature, how truly evidence-informed is the labeling of swaddling as a "risky" behaviour?

The BPG points out that low socio-economic status is a risk factor, yet provides no guidance as to how an RN may ameliorate said risk. What is the "best" approach with a family whose heat has been shut off, and shares one family bed? Simply telling the parent(s) they're risking their child's life by swaddling and/or bed-sharing will only alienate and further marginalize this client.

Finally, there is no mention of the quality of primary studies supporting the assertion against co-sleeping. The BPG makes note, however, that the evidence demonstrating pacifiers' possibly protective effect against SIDS is fraught with "methodological limitations." Why the disparate treatment?

Lyndsey McRae
Toronto, Ontario

Publisher's Note

The research study in question (*Blair et al., 2009*) found that infants' exposure to tobacco smoke was not a significant risk factor for SIDS, whereas swaddling was reported to be a significant, independent risk factor. RNAO BPGs consider any and all such high-quality papers as important contributors to the evidence. To the second point of concern raised by the writer, recommendations specific to families of low socio-economic status were beyond the scope of this BPG; however, this is an excellent point and future editions of this BPG will consider it.

Recommendations are assigned a level of evidence (ranging from 'one' as the highest level of evidence, to 'four' as the lowest) to reflect the type and quality of the research they are based on. To the writer's third point of concern, the recommendation about co-sleeping received a level three rating, which by its definition means well-designed descriptive studies supported it. Recommendations based on expert opinion are rated as level four. This can mean either no formal research evidence was available or that the available research was appraised as low quality, as was the case with the recommendation about pacifiers.

Have you read something in the magazine that's piqued your interest? Raised questions? Sparked an idea?

Write a letter or opinion piece no more than 250 words. Tell us what you're thinking at letters@RNAO.ca. RNAO reserves the right to edit for length.

NURSING IN TH

Nurse saves golfer hit by lightning

ICU nurse **Chris Burden** has been hailed a hero after reviving a man who was struck by lightning on a Stouffville golf course in June. Burden and his brother were taking shelter from a severe thunderstorm in the course's clubhouse when lightning struck, shaking the building. They went outside and found four people injured, including a 60-year-old man lying face down near the 18th hole. He wasn't breathing and had no pulse. "His body was burned, his face, his hands, everything we could see was burned," Burden recalls. "His eyes had rolled into the back of his head and it was just purely instinct to start CPR." The brothers performed CPR as it continued to storm overheard, and after a few minutes the man began breathing and opened his eyes."I started looking at my brother as if to say... I think we got him back." The man was taken to hospital in critical condition, while Burden and his brother, a police officer, returned to the clubhouse for a burger. "We're public servants. We do our job for others, we don't do it for ourselves," Burden says. "So the hero thing, it's a title. I just did what I knew I could do in that situation." (*Global News*, June 18)

PHOTO: SJOERD MITTEVEEN

Chris Burden (front left) poses with ICU colleagues at Markham Stouffville Hospital. (L to R) Debora Coles, Lorene Desnoo, Carlyn Tancioco, Cindy Pearson, Norma Clarke and Diane Schmidt.

Chronic pain costly and misunderstood

It affects one in five Canadians, contributes to depression and suicidal thoughts, and costs billions in health-care expenses and lost productivity. Notwithstanding these troubling statistics, chronic pain is often misunderstood, says nurse clinician scientist **Jennifer Stinson**. "A lot of people think that chronic pain is something only older people get, but in fact one-in-five children also suffer from recurrent or chronic pain," she says. The most common examples of chronic pain include headaches, abdominal pain, and musculoskeletal pain. Despite this, it can be difficult to diagnose, Stinson admits. "Health-care providers, the public, even (the patient's) friends don't believe they have chronic pain, because for most of the conditions, it's invisible," she says, adding "they look perfectly normal... but this pain has a significant impact on their life." Many Canadians have limited access to proper pain care, and others wait more than a year to see a pain specialist. More than half of Canadians waiting for care at pain clinics report suffering from depression, while nearly 35 per cent say they've considered suicide. (*CBC.ca*, June 21)

Take a step back to address health inequity

To combat the "social pandemic" of health inequity, RN **Salma Debs-Ivall** says we must look at the bigger picture of health care. "We're always concentrating on health services. That's where we are putting the majority of our resources, (but) health services themselves have the smallest influence and impact on illness trajectory and health," says the project manager at The Ottawa Hospital. "We need to take a step back... (and look) at behaviours and exposures," including education, employment, housing, smoking and drinking. Debs-Ivall was the keynote speaker at the Seaway Valley Community Health Centre's annual general meeting in June, where she

E NEWS

BY DANIEL PUNCH

told attendees that prevention is one of the keys to improving overall public health. She says health-care providers must look at social and environmental factors. "What is the neighbourhood (the patient is) living in? Do they have access to the right resources? Do they even have access to a primary care physician?" She says a solution will require collective action from individuals, government, businesses and agencies. (*Cornwall Standard-Freeholder*, June 27)

RNs take action against "illogical" cuts to refugee health care

Federal cuts to refugee health care must be reversed to restore basic human rights for vulnerable people, say Ontario nurses who joined in several demonstrations as part of a *National Day of Action* on June 16 to protest cuts to the Interim Federal Health Program (IFHP). "People come to this country to find shelter so it doesn't make any sense (that the federal government) did this," says Mississauga RN **Maria Tandoc**. "The policies they implemented are illogical and wind up costing more money," (*Mississauga News*, June 17). Changes to IFHP were introduced in June 2012 as cost-saving measures, but a study by Toronto's Hospital for Sick Children (SickKids) showed costs may actually be increasing. Since the cuts, SickKids saw admission rates for refugee children double as more families were forced to resort to expensive emergency department

Maria Tandoc speaks out on behalf of nurses attending a rally in Mississauga on June 16. RNs at similar rallies across Ontario called cuts to refugee health "illogical."

visits. "Health-care professionals critical of this decision at the time predicted this would happen," says RNAO President **Vanessa Burkoski**, and "now we are seeing the results of the federal government's faulty logic," (*Sun News Network*, June 14). In December 2013, Ontario joined five other provinces and temporarily reinstated urgent care for refugees, sending the bill to Ottawa. This July, the Federal Court overturned changes to the IFHP on grounds they were unconstitutional, a decision the federal government says it will appeal. (For more on this, check out *Policy at Work* on page 17.)

Protecting the environment becomes an election issue

As Ontarians prepared to visit the polls for the June provincial election, two health-care leaders reminded voters that a healthy environment is paramount to a healthy population. RNAO CEO **Doris Grinspun** co-authored an op-ed in *The Hamilton Spectator* with **Gideon Foreman**, executive director of the Canadian Association of Physicians for the Environment. The pair expressed concern that environmental gains over the last two decades could be undone by a new Ontario government. "Before Ontarians enter their voting booths, they should remember the significant progress we've made protecting our environment and health," the column states. The *Drive Clean* program, *Green Energy Act*, ban on lawn pesticides, closure of the province's coal plants, and other environmental initiatives "have meant a major improvement in the quality of life and health of Ontario residents," Grinspun and Foreman wrote. After winning a majority government on June 12, Premier Kathleen Wynne introduced legislation that could permanently ban coal burning as a source of energy in Ontario. (June 10) **RN**

Letter to the editor

Elgin County public health nurse **Rosemarie Vandenbrink** *pens a letter to the* St. Thomas Times-Journal, *warning drivers to keep their eyes and attention on the road.* (June 11)

Distracted driving can be deadly

Distracted driving can and does kill and injure. It is not worth the risk. A driver who is doing something else when driving is four times more likely to be in a crash, compared to a driver who is concentrating on the road and the job of driving. Distracted driving contributes to at least 30 to 50 per cent of traffic collisions in Ontario (according to Ontario Provincial Police statistics). These collisions are not accidents. All these deaths and injuries are preventable. Ontario Provincial Police have said distracted driving is the number one killer on our roads. This culture of doing more than just driving is a culture each and every one of us must work toward changing. We all need to use common sense. Does a task take your eyes or attention off the road? Don't do it. Safe driving requires a driver's full, undivided attention. Remember, driving is a privilege, not a right. You have the power to prevent injuries and collisions. Just drive.

PHOTO: CHRIS CLAY, COURTESY OF THE MISSISSAUGA NEWS

NURSING NOTES


PHOTO: TECKLES PHOTOGRAPHY INC.

Karima Velji

Two Ontario RNs take centre stage at national convention

RNAO member Karima Velji was officially installed as the 46th president of the Canadian Nurses Association (CNA) during its biennial convention in Winnipeg in June. "I want to inspire my fellow nurses to realize the powerful difference we are making in the lives of those we serve," she said about taking on the role, "…so we can safeguard the exceptional trust Canadians place in us."

Until 2013, Velji was chief operating officer and chief nursing executive at Toronto's Baycrest, a leader in innovations on aging and brain health. Before that, she was VP, patient care, and chief nursing executive at the Toronto Rehabilitation Institute.

Another RNAO member, Bonnie Stevens, was recognized with an *Order of Merit* for exceptional leadership in nursing research at the CNA convention. Stevens is recognized as a world expert for research on the assessment and management of pain in infants and children. She directs the University of Toronto's (U of T) Centre for the Study of Pain, and co-directs the Centre for Pain Management Research and Education at the Hospital for Sick Children. For 13 years, Stevens has held the Signy Hildur Eaton Chair in Paediatric Nursing Research, the first endowed chair of its kind in Canada. She earned her bachelor of nursing from McMaster University, her master of science in nursing from U of T, and her doctorate from McGill University.

Recommendations to prevent elder abuse released

On June 13, RNAO unveiled more than 20 recommendations aimed at helping nurses and other health-care providers prevent and speak out about elder abuse and the neglect of older adults. The recommendations were revealed ahead of the official unveiling of the association's latest BPG, *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches*.

RNAO wants all health-care providers to consider the rights of older adults when it comes to lifestyle/care decisions before determining interventions and supports. Doing this could mean a decrease in instances of physical trauma, feelings of low self worth and dignity, a lost sense of safety and security, and even an increased risk of early death for those at risk. Other key recommendations speak to mandatory education for anyone serving older adults. That education would focus on ageism, the rights of older adults and the types, prevalence and signs of abuse and neglect, factors that may contribute to abuse and neglect, and individual roles and responsibilities with regard to responding to and reporting abuse or neglect.

"We hope RNAO's BPG will be adopted by all health-care organizations and individual providers to help put an end to what can only be described as a horrifying and hugely troublesome trend," RNAO CEO Doris Grinspun says.

Visit www.RNAO.ca/elderabusebpg to access the BPG, set for release in the summer of 2014.

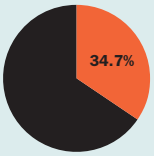
In memoriam

RNAO EXTENDS ITS DEEPEST CONDOLENCES TO FAMILY AND FRIENDS OF

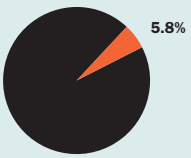
Christine Kent, who lost her battle with breast cancer on July 13. Christine was an active member of RNAO's Region 10, and was membership officer for the Staff Nurse Interest Group.

CIHI nursing data released

In early July, the Canadian Institute for Health Information (CIHI) released its latest national nursing numbers. Some of the noteworthy findings:



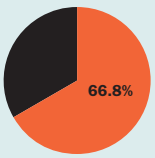
Ontario's share of total RN employment dropped from 35.4 per cent in 2009 to 34.7 per cent in 2013.



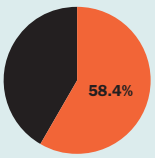
The male share of the RN workforce rose modestly to 5.8 per cent between 2009 and 2013. Ontario lags behind the national number, which rose to 7.1 per cent.

The full report is available at www.CIHI.ca

The average age of Ontario RNs has fluctuated over the last four years, rising to 46.7, and then falling again to 46.5. Nationally, the average has followed a similar pattern, jumping to 45.5 before falling to 45.1.



Ontario's full-time employment ratio increased from 65.6 per cent in 2009 to 68.6 per cent in 2012. It then dropped in 2013 to 66.8 per cent.



Across Canada, **the full-time employment average** was 58.4 per cent in 2013.

 BY MELISSA DI COSTANZO

Unique role allows RN to make a difference in short term

KIM FRANCHINA HAS SEEN FIRSTHAND THE BENEFITS OF FOCUSED ATTENTION FOR PATIENTS WITH SICKLE CELL ANEMIA.

If the young Kim Franchina was told she'd become a nurse, the now 52-year-old is confident her reply would have been 'you're out of your tree.'

"I didn't think I had it in me," she now admits.

Instead, she began her career working in admin for the federal government. When she was in her 20s, Franchina's father was admitted to hospital with heart issues. Unable to figure out which machine did what, and how to keep a closer eye on her dad's vitals, she felt helpless, an experience that sparked her interest in becoming an RPN. She graduated in 1988, and immediately signed up for a three-year RN diploma program.

Franchina didn't stop there. With encouragement from her father, who is now 87, she worked towards her bachelor's degree, wrapping up those studies in 2013. She says she was inspired to get her BScN after completing two RNAO fellowships that focused on pain management, specifically in palliative care and end-of-life care. The fellowships, a departure from her areas of practice (weight management and then, for a decade, haematology oncology), were completed around the same time she earned her degree. She says the experience helped her to snag a unique position as part of an 18-month pilot project at The Ottawa Hospital.

Franchina acted as care co-ordinator for over 100 patients with sickle cell anaemia, a chronic disease caused by sticky, crescent-shaped blood cells that can block blood flow to limbs and organs, causing a litany of issues, including difficulty breathing, a lack of energy, and pain.

Individuals who are living with sickle cell anaemia show up in the ER when they experience sudden pain. Some physicians worry about prescribing high doses of powerful narcotics, yet this is something many sickle cell patients are used to. Physicians often prescribe half the dose, but "you're just prolonging (the pain)," Franchina says.

To help doctors feel more comfortable prescribing higher doses to sickle cell patients, and to ensure the pain was treated appropriately, Franchina created booklets for patients to carry at all times. They outlined a typical dose, and listed the contact information for the appropriate doctor. Franchina's pager number was also printed in the booklets.

Hosting lunch-and-learns and offering sickle cell advice to any hospital staff that needed it was also part of her role. Franchina helped colleagues better understand how her patients cope with pain. "They've learned how to manage it so you don't necessarily see those manifestations like writhing in bed or crying," Franchina explains. "Some watch movies, or rest quietly."

Franchina helped her patients figure out foods high in iron, to help combat their low haemoglobin, and how to exercise, even with sore joints. She mailed birthday cards and even purchased a jacket for one patient she saw smoking outside in the dead of winter with a tattered coat. "Anybody who knows me knows that (I give) 110 per cent or nothing," she says.

Franchina marked Sickle Cell Awareness Month (September) by raising $1,500 through a charity bake sale at the hospital in 2011. The proceeds went towards taxi chits (for patients unable to access other forms of transportation) and other necessities for patients (such as thermometers because colds can pose serious health challenges for these patients). She also helped teenagers at the Children's Hospital of Eastern Ontario transition to The Ottawa Hospital's adult care centre by meeting the adolescents and offering to take them on tours of the adult facility.

Funding for Franchina's unique role dried up last spring and she was forced to switch gears, moving to The Ottawa Hospital's acute leukemia and bone marrow transplant unit. "It was really heartbreaking," she says, because there are still more than a hundred sickle cell patients who need focused support. She hopes that, one day, the sickle cell patient population will have a co-ordinator. Still, she says "even if all I gave them was 18 months, I made a difference." She's applying for another fellowship this fall and has begun her master's. "As long as I feel like I can make a difference, I will keep going." **RN**

Three things you don't know about Kim Franchina:

1. She is an avid road cyclist.
2. Nicknamed Mighty Mouse (she's 5'3"), Franchina claimed the title of Ottawa's Strongest Woman (2004/05) and has also been named the North American Arm Wrestling Pro.
3. She has two Chihuahuas: Chester and Picco.

MELISSA DI COSTANZO IS STAFF WRITER AT RNAO.

Harvesting good health

Registered nurses who care for migrant farm workers are helping to mitigate barriers and manage health concerns for those temporarily living far from home. BY MELISSA DI COSTANZO

Felix travels from Mexico to Ontario year after year to help with the harvest at a Cobourg farm.

Sample boxes of Tylenol and Advil peek out of Lydia Rybenko's home visit bag, and a stethoscope is surreptitiously unfurling. It's 6 p.m. on a Thursday in June, and the nurse practitioner, clad in turquoise capris and a paisley top, has arrived in Cobourg, a 15-minute drive from the Port Hope Community Health Centre, where she works as clinical director.

Her destination is a cramped – but cozy – second floor space in Cobourg's New Canadians Centre that will serve as a makeshift exam room until the harvesting season ends.

A fan lazily oscillates, circulating sticky air, as Rybenko empties her satchel. Out come the traditional pain medications, followed by blood pressure management tablets, a blood pressure metre, an instrument for peering into patients' ears, client documentation and a prescription pad. These are, for the most part, the only supplies she'll need for the patients she's about to see: mostly males around the age of 40 who come to Canada each year to work on farms and in greenhouses. Rybenko will monitor these seasonal migrant workers for hypertension, renal disease, diabetes or chronic obstructive pulmonary disease. She also treats upper respiratory infections, diarrhea, strains and sprains. The few women workers seeking the NP's care are typically looking for birth control, or treatment for sore feet.

Felix, a migrant farm worker from Mexico, attends Lydia Rybenko's clinic on Thursdays to check his blood pressure and for general health advice.

Once unpacked, Rybenko peers out the window. She's looking for the rust-coloured school bus that transports about 20 migrant workers from a local farm into town each Thursday, a weekly excursion from 6 to 8 p.m. that coincides with the NP's time in town. It's payday, which means many of the 100 workers who come to the region each year from their hometowns in Mexico, Jamaica and Guatemala will visit the bank, grocery and convenience stores. Some visit with Rybenko.

The NP has been running this free, drop-in primary care clinic for local migrant farm workers for four years. She works in tandem with Luz Ofelia Maya, a new settlement worker from Colombia who doubles as a Spanish translator (about 10 per cent of Rybenko's patients don't speak English). Maya, who develops a rapport with the local farmers, will also travel to four or five local farms and post the dates and times of Rybenko's clinics.

Their successful partnership began after a mutual colleague reached out to the Port Hope CHC after noticing many workers visited Cobourg's Northumberland Hills Hospital ER for non-urgent health-care issues. In many cases, they didn't know where else to go, or what kind of health-care coverage they were entitled to.

Rybenko helps to prevent chronic illnesses from developing into critical cases, and ensures this vulnerable population's care needs are met while they're far from home. She's one of a handful of Ontario nurses caring for workers who arrive through the federal Temporary Foreign Workers Program. In Ontario, many of these individuals are concentrated in the Leamington, Simcoe and Niagara regions, which have rich agricultural roots.

Sadly, their health often takes a backseat, presenting unique challenges for nurses like Rybenko. She normally sees between six to 13 patients at each clinic. Tonight, she'll see just one.

Felix is Mexican, soft-spoken, and in his 50s. He's travelled from his lodging – a house on a local farm – to see Rybenko. He offers his arm and she pumps up the blood pressure cuff. She asks him if he has his hypertension medications. He responds quietly, "no" and continues speaking Spanish. Maya translates: he says he's left them in Mexico.

Rybenko checks his pulse, listens to his heart. "When was the last time you had your medication?" she asks.

Maya gasps at the response: four months.

"Por que?" Rybenko asks, containing her admonishment (she doesn't want to come across as authoritative; she wants her patients to make informed choices, she later says). Again, a vague response.

Rybenko and Maya are convinced Felix won't pay $70 to $80 on medications. Workers, who typically earn minimum wage ($11/hour), spend the bare minimum on food and clothing, and save thousands to take back home to their families. Some build homes with the money they make in Canada. Others fund their children's education.

For many, these jobs are a lifeline, and spending money on medication is costly.

Rybenko tells Felix that his blood pressure is low now because he's sitting and calm. When he's picking strawberries in the summer heat, it's a different story. His blood pressure will skyrocket, putting him at risk for a heart attack, stroke or kidney failure. "They don't necessarily get this education when they're at home," she later says.

The nurse remembers having this same conversation with Felix last year (many farmers will request some workers return annually). His leg jiggles.

She pulls four boxes bound together by elastic – 40 pills – out of her bag and tells Felix to take one a day. She wants to see him in two weeks. He nods and smiles.

"It just shows you how important (work) is for them, when they sacrifice their well-being," she says. "Their priority is making money. Everything else is secondary."

Rybenko will give patients like Felix sample medications. Some of the local pharmacists have also agreed to waive the $5

PHOTO (THIS PAGE & PREVIOUS): JEFF KIRK

dispensing fee. Every little bit helps, she says. "They're out there, they're picking our food, they're bringing it to the market, and there are a number of us in the community who feel we've got to give something back."

More than 38,000 legal temporary contract positions are available in Canada for migrant farm workers, with more than 50 per cent in Ontario's agricultural sector. Annually, roughly 20,000 workers travel from Mexico, the Caribbean, Thailand and Guatemala to work on Ontario farms and in greenhouses across the province.

Their hours are long (up to 60 per week, often more during busy periods) and they're at it for six or sometimes seven days a week. It's demanding work that can contribute to various health issues, including osteoarthritis, musculoskeletal strains and eye, skin, respiratory and neck problems.

Although migrant farm workers pay taxes and have health-care and extended WSIB coverage, some don't know how to access these services. And many fear they will be repatriated if their employer learns they have a health issue, or have visited a clinic for care. "(Farmers) hire them with the expectation that they're going to be well, and they're going to be doing the job," says Rybenko."Sometimes, these guys won't even identify how sick they really are, for fear of being sent home."

Those who want – or need – care often face multiple barriers. Many walk-in clinics operate 9-5. That's why Rybenko schedules her clinics when workers are already in town, and after a day in the field.

The staff at Quest Community Health Centre in St. Catharines is also mindful of migrant farm workers' limited free time. Sundays from 3 to 6 p.m., from May until October, the CHC offers migrant farm workers a series of clinics. They've been doing so for the past four seasons, thanks to donated space.

The Niagara area is dense with migrant farm workers. There are as many as 8,000 employed in the catchment area covered by the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN). The Niagara Fruit Belt, 65 kilometres extending from Hamilton to Niagara-on-the-Lake, is also within the LHIN's boundaries, and produces 90 per cent of Ontario's tender fruit crop, including peaches, pears, wine grapes and nectarines.

Between 20 to 35 workers typically show up at each of Quest's Sunday clinics. Workers are seen by an NP or physician, RN or RPN, and other health professionals, including a community health worker, dietician and client co-ordinator. Nursing and medical students from nearby Brock University, and a team of three to five volunteer translators also contribute. RN Emily Kedwell has staffed past clinics, and says nurses tend to take on the role of triaging patients, or providing health teaching. Chronic disease management (especially for diabetes) and self care for soft-tissue injuries and eye protection are usually the main topics.

Providers run into challenges when workers need to see specialists, or get blood work at laboratories that are not usually open outside of regular business hours. Reluctant to spend time away from the farm, migrant workers will often skip these appointments.

Knowing this, there are some nearby labs that stay open, and Kedwell encourages her patients to go. She also helps them to access other accompanying services to avoid appointments that conflict with work hours – for the sake of their health.

Quest's model is well-established after four years, which means other CHCs have come calling for tips. Brantford's Grand River CHC is one of them.

Quest and Grand River each received $75,000 from the HNHB LHIN in March 2014 to provide primary health care to migrant farm workers. The care must be in languages and at times/locations accessible to farm workers. Quest will use the money to expand its existing services. Grand River is developing a new program in the neighbouring Norfolk region, which is just getting off the ground. It's currently staffed by an administrator, two translators and a physician.

Mary Falconer has picked her fair share of strawberries and knows what backbreaking labour feels like. The RN grew up in a small town northeast of Sarnia, where her family tended to baby pigs and raised over 40,000 turkeys.

This upbringing, she says, has helped give her "edge and comfort" in her role as a part-time RN with Occupational Health Clinics for Ontario Workers (OHCOW), a collection of clinics in Hamilton, Toronto, Sudbury, Thunder Bay, Sarnia-Lambton and Windsor.

But most of Falconer's work with migrant farm workers takes place outside the walls of these clinics. For four years, the RN has travelled to as many as 40 farms each year in the Sarnia-Lambton area to help prevent work-related health problems and to provide health and safety information. She hosts presentations and drops off informational packages. "If you're invited on the farm, you're invited into their home," she says of this key first step in developing a connection with a farmer. "You have to earn the right to be there." That's where her childhood experience comes in handy.

Nursing student behind resolution


Erin McMahon

Palliative care nurse Erin McMahon worked on a farm about 20 years ago in her hometown of Woodstock. She unloaded truckloads of tobacco, and says the experience helped the then-McMaster University student relate to migrant farm workers. In 2011, the challenges they face came into sharper focus when she attended a conference and learned about allegations of workers being fired because of sickness or injury. She heard about their reluctance to access health care for fear of termination and repatriation. "What I learned there blew me away," she says, adding the revelations made her think: "as a nurse, I can advocate for this cause."

Through a placement at Woodstock Public Health, McMahon met RN Mary Metcalfe. They teamed up, and in 2012 submitted a resolution calling for strategic partnerships with the provincial government to invest in solutions to remove the barriers to care faced by migrant farm workers.

As a result, RNAO developed links with the Occupational Health Clinics for Ontario Workers, the Migrant Health Worker Project and Wilfrid Laurier University. It continues to work with community allies on improving health and health care for migrant farm workers.

The resolution, which McMahon says "gave these people a voice," is one example of how members channel their desire to make a difference. For more, turn to page 23.

Her focus is on farms with fewer than 50 workers (greenhouses that employ closer to 600 usually have health and safety departments). Her coverage area spans from Sarnia and Leamington to Essex and Chatham-Kent, where farmers' major crops include lettuce, tomatoes, carrots and apples.

Falconer covers a slew of topics during her presentations, which take place over lunch hour so workers can make the most of their work day. She discusses heat stress, basic ergonomics like safe lifting, working with pesticides, and the importance of hand washing prior to and after using the toilet because of residual chemicals. She also offers education on the dangers posed by ticks and giant hogweed (a wild plant that can cause intense burns). She'll bring an interpreter and, because as many as 60 per cent of workers don't read in their own language, pictorial handouts. Falconer answers questions about workers' health concerns, and will direct them to a local clinic or hospital for follow-up care.

Over 25 per cent of migrant workers' injuries are sprains, strains and back injuries, so Falconer encourages workers to perform warm-up exercises and basic stretches, and to rotate jobs every hour, if possible. "The simple little things (stave off) big injuries," she says.

Like Falconer, RN Michelle Tew also works with OHCOW. She's based out of Hamilton, the catchment area with the most migrant farm workers in Ontario, and has been organizing and conducting clinics for this population since 2006. "When we started...we thought we'd be talking to them about occupational health issues," she recalls. "What we...realized was that...if it was a primary care issue...there was no place else for them to go."

She and her team offer workshops, and will present on farms and at health fairs. One year, after learning up to a third of workers attending the clinics developed an eye condition such as conjunctivitis (pink eye) or other forms of irritation, OHCOW received funding to provide safety glasses. Tew visited farms to talk eye safety, and the conditions that can develop as a result of too much sun exposure.

Tew also attends informational fairs for workers, which usually take place at the beginning of the season. One such event happened in Niagara-on-the-Lake in June. Hosted by the Niagara Migrant Workers Interest Group (Tew is a founding member), it drew a group of 10 workers who watched as a first responder demonstrated how to use a defibrillator, and then performed CPR on a dummy.

At similar events, nurses are on hand to conduct free basic eye exams, blood pressure and glucose level tests.

Michelle Tew shares health information at a clinic for migrant workers in June.

In addition to clinical and program development, advocacy is a significant part of Tew's role. Last year, she partnered with the Association of Ontario Health Centres to pursue dedicated primary health-care services for migrant farm workers. This helped to secure funding for Quest and Grand River CHCs. She's also organized stakeholder gatherings consisting of employers, government ministries and other advocacy groups. "These workers leave their family to come here to contribute to our quality of life," she says. "They are not recognized enough for their contribution."

Back in Cobourg, it's been two weeks, and Felix is back for a follow-up appointment with NP Rybenko. He has been taking his medication, and his blood pressure has stabilized. She asks if he has chest pain, swelling, or has been coughing. No to all. "He's doing well," she says.

In another two weeks, she'll do blood work. If he'll let her, Rybenko wants to do a full cardiac workup, including a stress test and echocardiogram, rounded out with a conversation with an internist to rule out coronary artery disease. But that's probably going to take five or six hours at the hospital, she acknowledges. "I tried to get him to go last year, and he didn't," she says. "I'll certainly keep trying." **RN**

MELISSA DI COSTANZO IS STAFF WRITER AT RNAO.

TFWP and SAWP

Migrant farm workers come to Canada through the federally run Seasonal Agricultural Workers Program (SAWP) and various other streams of the Temporary Foreign Workers Program (TFWP). If the latter rings a bell, it's because of recent changes to the program, sparked by accusations this spring that a fast-food franchise in B.C. was favouring foreign workers over Canadians. Similar stories followed.

In June, the federal government introduced changes to the program that limit the time migrant workers can stay in Canada, increase application fees, and place restrictions on migrant worker hiring by employers (among a litany of other reforms). The Migrant Workers Alliance for Change, the country's largest migrant worker rights coalition, says the changes will result in migrant workers being "less able to assert their rights."

Most migrant farm workers come to Canada through SAWP, which is exempt from many of these changes.

POLICY AT WORK

Cuts to refugee health care labelled "cruel and unusual"

Hamilton residents gathered at one of many rallies for refugee health across the province on June 16. Leanne Siracusa spoke on behalf of RNAO and its Hamilton chapter.

RNAO was among several groups applauding a federal court decision in July that ruled Ottawa's changes to health coverage benefits for refugees are unconstitutional. Justice Anne Mactavish said the policy brought in two years ago by Prime Minister Stephen Harper's government violates sections of the country's *Charter of Rights and Freedoms* that prohibit "cruel and unusual" treatment. In her ruling, the judge said the cuts to health benefits have had a "devastating impact" on refugees and put lives "at risk" as a result. The changes forced refugees to pay for life-saving medications such as insulin. Newcomers were also denied dental and vision care. When the changes to the Interim Federal Health Program (IFHP) were first announced in 2012, RNAO responded by writing letters to the prime minister and Ontario's premier, calling on members to do the same. The association was a visible presence at several rallies organized to draw attention to the loss of health benefits and the federal government's lack of compassion towards refugees. Ottawa has four months to make changes to the IFHP. However, immigration minister Chris Alexander said the government plans to appeal the ruling. RNAO will continue intense actions to ensure the court ruling is upheld.

RNAO policy analyst Andrea Baumann (left) represents RNs and RNAO at a minimum wage rally outside the Ministry of Labour's Toronto office.

Joining the "You deserve a raise" campaign

An increase in the minimum wage to $11 per hour wasn't enough to convince RNAO that Premier Kathleen Wynne's newly elected provincial government is doing all it can to help the working poor. RN and RNAO nursing policy analyst Andrea Baumann represented the association at a rally on June 18 alongside other health, anti-poverty and labour groups. A 12-metre long petition containing thousands of signatures was rolled out in front the Ministry of Labour's Toronto office. The groups want the minimum wage raised to $14 per hour, arguing $11 leaves full-time minimum wage earners below the poverty line.

Taking aim at privatization

More than 1,200 RNs, NPs and friends of RNAO responded to an action alert in July calling on the Liberal government to ban medical tourism and for-profit plasma collection. Examples of medical tourism, which is the practice of charging patients from abroad for surgeries and other medical attention, have been documented in several Toronto hospitals. RNAO says the practice undermines the province's publicly funded, not-for- profit system by creating a different class of patient that receives front-of-the-line access in exchange for payment.

Members also responded to the action alert to voice their views on the collection of for-profit plasma. Paying donors for blood or blood products compromises the voluntary nature of the program and threatens the blood supply system, the alert notes. Members want it to stop.

RNAO is opposed to any attempt to make a profit from the provision of health services.

The province has re-introduced Bill 178, the *Voluntary Blood Donations Act*, which was first tabled by former Health Minister Deb Matthews to prevent two clinics from opening in Toronto that would have provided payment to plasma donors. The original legislation died when Premier Wynne dissolved the legislature on May 2. **RN**

To find out more about RNAO's political action and policy work, visit www.RNAO.ca/policy

It takes a TEAM

Members have once again answered RNAO's call for personal narratives that make up the annual collection of stories in the summer issue of *Registered Nurse Journal*. This year, we asked nurses to write about their experiences collaborating with other health providers. The stories feature members who work in the remote reaches of the Arctic Circle, in community geriatric care, hospice/palliative care, rehab and complex continuing care, and acute care. Their reflections offer compelling anecdotes that describe what interprofessional practice means to them. Thank you to each and every member who submitted a story for consideration this year.

COMPILED AND EDITED BY KIMBERLEY KEARSEY

Transition from RN to NP is easier with support from colleagues

By Lan Zhou

Nurse practitioners are required to exercise a high degree of independent judgment, provide comprehensive health assessments, and make clinical decisions to manage acute and chronic illnesses and promote wellness. For new NPs, the development of skills for this advanced practice role requires collaboration with other health providers such as RNs, RPNs, physicians, pharmacists, therapists, and social workers, particularly when caring for complex geriatric clients.

I graduated in 2013 from the MScN and primary health care NP program at York University. I was then hired to work in the geriatric medicine clinic at William Osler Health System, Etobicoke General Hospital. Although I already had 16 years of nursing experience in medical-surgical, ICU, post-anesthesia care units, and had done some NP clinical placements in the hospital, on a family health team, and in an NP-led clinic, I was still overwhelmed by the complexity of the geriatric patients in the clinic. Seniors can have complex health needs combined with socio-economic challenges.

One such client I helped was Cecile*, a 90-year-old widow with three children. She was suffering severe vascular dementia after a stroke two years earlier. She had a long medical history and her function was declining. She was dependant on her family for bathing, dressing and feeding. Cecile's appetite was very poor. She had difficulty sleeping, wandered, and tried to get out of the house at night.

If her family attempted to stop her, she would become very agitated and verbally and physically aggressive. The family was physically and psychologically stressed, and was struggling to make alternative care arrangements for their mom, who was on a one-year wait list for long-term care. They could not afford to hire a private personal care worker to provide respite care.

When Cecile came under my care, I knew I would need a lot of support given the complexity of her case. Fortunately, there was always a geriatrician working collaboratively with me. I also teamed up with other colleagues in pharmacy, community care, social work, and the Alzheimer's Society to offer Cecile care that was truly collaborative. Cecile was able to move into long-term care within one week, and her family really appreciated this outcome.

This experience showed me the importance of interaction and collaboration with other disciplines. It has significantly influenced me as I transition into this advanced role, and has allowed me to provide comprehensive, high quality of care to patients and their families.

** Pseudonyms have been used to protect privacy*

ILLUSTRATIONS: JULIA BRECKENREID

RNs tackle trauma in the north

By Jannine Bowen

In the late 60s, psychiatrist Leonard Stein published his now famous essay about the "doctor/nurse game." He wrote: "...the nurse is to be bold, have initiative, and be responsible for making significant recommendations, while at the same time she must appear passive. This must be done in such a manner so as to make her recommendations appear to be initiated by the physician." Revisiting that theory in the 90s, Stein admitted the "game" is no longer played. Any nurse working in an isolated, northern community is likely to agree with him. I do.

In the frozen, isolated tundra, above the Arctic Circle, our health centre serves about 900 Inuit people. There are three full-time nurses – supported by wonderful local staff – who are responsible for taking initiative and making recommendations for patient care, and often making life and death decisions on the spot.

One such instance was at 23:00 on a July night in 2012. The call came in that two young boys who had been drinking and smoking marijuana got on their all-terrain vehicles (ATV) to race up and down a gravel hill, and crashed. At the health centre that night: three community health nurses with combined expertise in emergency and ICU nursing. What follows is a testament to nurses' ability to come together to provide the best possible care, with the least amount of support. There were no "games" on this night.

A male teenager arrived on a piece of plywood and was taken to the only trauma room we had. As we started the primary survey and interventions, the crowd got bigger, the room got smaller and the nervousness grew. Above the crying, someone was screaming as they carried in the second teenager. "Where do you want him?"

"Right here on the floor in front of me," I said, glancing at the distracting deformity on his left leg. A local teenager did the primary survey: unconscious and not breathing. "Do you know CPR?" I asked him. He nodded. "Then start compressions."

We took the defibrillator leads from the first teenager and applied them to the second. No shockable rhythm. Two nurses continued on life-saving measures while the third connected with the on-call doctor by phone. After three rounds of life-saving measures, the code was stopped and we had to turn our attention back to the surviving teenager on the stretcher. The crowd continued to multiply. The crying escalated. With one boy clinging to life, the Medivac team was called, but our hearts were sinking in our chests as a mother bent over her lifeless son on the floor.

This shows the "doctor/nurse game" no longer applies. In the north, it is the nurse, the community, and the grace of God and his spirit that guide you to do the best you can as a team.

Team comes together to send patient home for Christmas

By Karimah Alidina

Interprofessional practice means working collaboratively and using evidence to provide the best quality, patient and family centred care. Having a multi-disciplinary team doesn't necessarily mean the care provided will be interdisciplinary. For me, interprofessional collaboration implies an interaction between different professions that is more organized and addresses common patient goals. When members of a team feel excited about collaborating, and when the outcomes are more co-ordinated, effective and timely, that is truly interdisciplinary care in action.

In December 2013, I was working at a hospice in Oakville when I had the pleasure to meet and care for a 43-year-old man named John.* He had bladder cancer. John had a very loving family, including a very young wife and toddler twins.

> "Talking to him made me realize that he knew it was his last Christmas, and he was hoping to go home for Christmas Eve."

When I first went to see John in his room, I saw him signing Christmas cards and individually wrapping the gifts for his family and friends. Talking to him made me realize that he knew it was his last Christmas, and he was hoping to go home for Christmas Eve.

John was retaining blood clots in his urine resulting in frequent blockages of the urinary catheter, requiring bladder irrigation. In order for him to go home, the team had to ensure his catheter drainage and pain was well managed away from the facility. The team, which included nurses, a palliative care physician, a hospice co-ordinator, and a personal support worker, met with John and his wife to develop a plan to support his goal of going home.

A urologist was also involved, who came to the hospice and performed a procedure to insert a larger catheter to prevent clot retention. The nurse and palliative care physician created a well-documented plan to manage John's pain at home.

Despite several challenges, John was able to go home that Christmas Eve. This is what truly interprofessional collaboration means to me. Each professional collaborated to ensure safe, high-quality care for the patient and his family.

It takes a TEAM

Collaboration translates into substantial change for TB patients

By Jane McNamee

As a nurse practitioner at Toronto's West Park Healthcare Centre, I have seen firsthand how collaboration can improve practice. I work for the Tuberculosis (TB) Service, a provincially designated treatment centre for complex cases of tuberculosis. We offer in-patient and out-patient services for sometimes drug-resistant cases of TB (known as multi-drug resistant or MDR TB). This requires multiple and potentially toxic medications for extensive periods of time. Amikacin is one such medication, and is only given intravenously over the span of several months.

For two years, I have wanted to implement a more concrete protocol for this medication because I have witnessed the damage it can cause, including permanent hearing loss. My chance to change practice came when the organization began hosting monthly education sessions. I volunteered with my colleague, a pharmacist, who also wanted to challenge current practice. Together, we presented basic information about Amikacin and the current TB guidelines for its use. My colleague was able to discuss recent studies, which support our concern that many patients suffer permanent hearing loss as a result of this medication.

Our goal was to draft a protocol to implement stricter monitoring for side effects and reduce the use of Amikacin. The existing practice certainly included monitoring, but it was ad hoc and lacked a formal structure. Our proposed new protocol was based on recently published Canadian TB Standards.

The fateful day of our presentation arrived, and I was worried about my just passable presentation skills. The assembled group included several physicians (with expertise in infectious disease and family medicine), respirologists, Toronto's medical officer health, and a number of other members of our team and the public health team. Despite my nerves, I was eager and passionate to implement change. The group was impressed with our synthesis of the material. We concluded by circulating a draft protocol based on our current practice. With all the key stakeholders around the table at the same time, the new protocol was reviewed and appropriate additions were made.

This protocol is now in practice on our unit. In fact, even before I was able to update the information, we began using it on our patient rounds the very day that we presented the material. I had no idea that in collaboration with others, I could achieve such substantial change.

Study group allows health professionals to collaborate through storytelling

By Michele Ivanouski (with contributions from Shannon Arntfield)

When working in a large health-care centre, staff can feel compartmentalized within their niche, whether it's newborns or geriatrics, emergencies or long-term care, diagnosing or treating. However, health-care providers do not work in isolation, and patient care plans can be the creation of many voices.

In 2011, a physician colleague, Shannon Arntfield, initiated the *Narrative Medicine Study Group* at London Health Sciences Centre. Within this interdisciplinary group, we use stories to teach that how care is delivered (the process) is just as important as what care is delivered (the content). This unique way of listening to patients has produced some surprising and inspiring results.

Each member of the group takes a turn leading the monthly meetings. We read and listen to stories from patients, families, and health professionals who have experienced care "on the other side of the fence" as a patient or family member. During one meeting, we used a foreign film to bring cultural end-of-life considerations to our discussions. Ideas flow freely between the group members, including dentists, ethics professionals, general practitioners and subspecialists, humanities professionals, medical students, midwives, nurses and university professors. It is a unique opportunity to share ideas in a non-judgmental and inviting environment. We wrap up each meeting by writing reflectively, in response to a prompt crafted by the facilitator.

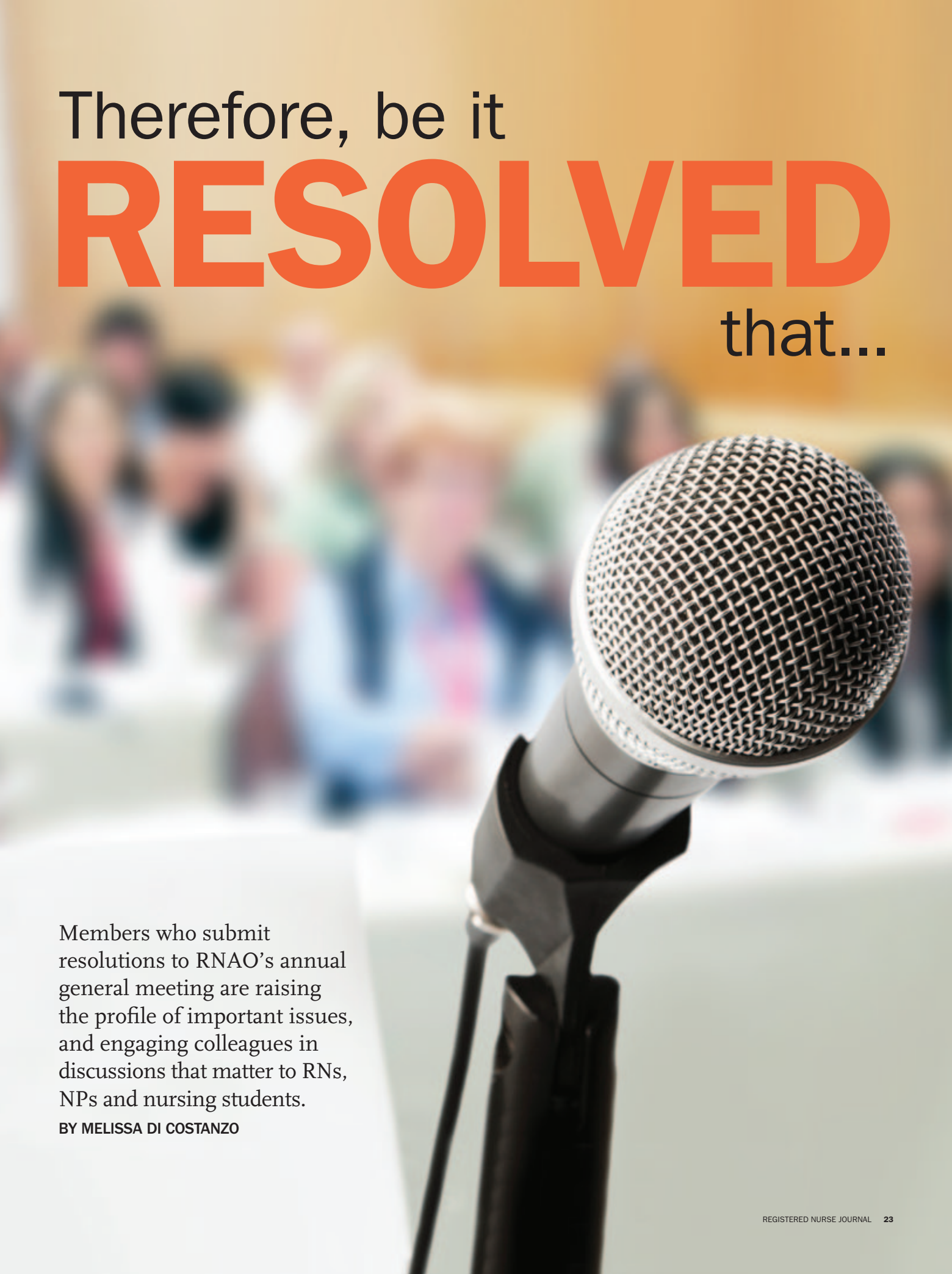
In one story, an organ donor's family described their son's body as a treasure chest of jewels. This created a surprising difference of opinion among the group. Some felt this boy's life had been reduced to objects: his organs. Others felt his family was describing a sense of fortune, that his final gift would impact the lives of others.

The *Narrative Medicine Study Group* initiated a public patient experience evening at the London Public Library. Through this, health professionals have the opportunity to engage and learn from those who have experienced illness. Their stories challenge us. One patient felt that if care providers had made more eye contact with him when he was a teenager, rather than his father, he would have felt more involved with his diabetic treatments. Another patient suggested that if caregivers would express regret that a previous plan did not work, she would feel more open to accepting new ideas.

This group work helps us hear patient journeys through many different professional and patient voices, and it inspires patient-centred care in all areas. Stories give us clues as to how green the grass truly is, or is not, on a patient's side of the fence.. **RN**

KIMBERLEY KEARSEY IS MANAGING EDITOR AT RNAO.

Therefore, be it RESOLVED that...



Members who submit resolutions to RNAO's annual general meeting are raising the profile of important issues, and engaging colleagues in discussions that matter to RNs, NPs and nursing students.

BY MELISSA DI COSTANZO

Wendy Fucile, former president of RNAO, facilitates discussion of the resolutions at the 2012 AGM.

> Our expertise is invaluable, and we have a mandate, as nurses, to take (our) knowledge and expertise and turn it into a way to affect policy.
>
> Wendy Fucile on speaking to a resolution in front of hundreds of colleagues

As Wendy Fucile listened to would-be politicians debate key issues during an all-candidate meeting in Peterborough 10 days before the provincial election, one thing became clear to the moderator and RNAO past-president: the community and its politicians care deeply about mental health.

Throughout the June 1 debate, organized by RNAO's Kawartha-Victoria chapter, Fucile took note as candidates from the Liberal, Conservative, NDP, Green and Socialist parties relayed anecdotes of families that have endured the pain of struggling to find support for a loved one living with mental illness. They lamented how support services are fragmented, and promised to improve access and funding.

There's potential to prepare a resolution on the pervasive and widespread issue of mental health for RNAO's next annual general meeting (AGM), Fucile mused.

Each year since the association's inception almost nine decades ago, individual members, chapters, regions without chapters, and interest groups have helped to shape the association's agenda by drafting resolutions that address pressing nursing, health and social issues. These resolutions are brought forward for discussion at the AGM, and, if approved by members, set the ball in motion to tackle the issues important to members.

"The discussion around resolutions is a central, core part of what (RNAO is)," Fucile says.

Resolutions run the gamut from changes to provincial (and sometimes federal) policy, to tweaking the association's guiding principles (the catchphrase, or tagline). In the past three years, members have called on RNAO to advocate for: the inclusion of males into the Ontario Grade 8 HPV publicly funded immunization program (2012); an integrated provincial strategy to address Fetal Alcohol Spectrum Disorder (2012); mandatory breakfast programs in all provincial elementary schools (2011); and basic and ongoing educational resources that enable nurses to meet the College of Nurses of Ontario's practice guideline for complementary therapies (2011).

And that's just a sampling.

The number of resolutions up for ratification each year varies. In 2010, a record 11 were submitted for discussion. This year, two were presented, an unusually low number that left Fucile surprised and disappointed. "The heart of the AGM, for me, has always been the dialogue that members have with each other around the key issues in nursing," she says, citing the conversations that take place when resolutions are debated on the floor. "(Our) richness, as an association...in part comes from the depth of this discussion."

Fucile admits that some members may feel intimidated about speaking to a resolution in front of hundreds of colleagues. But collaborating with other members, chapters and interest groups can help ease that anxiety (multiple signatories are allowed on a single resolution at the AGM). "Our expertise is invaluable, and we have a mandate, as nurses, to take (our) knowledge and expertise and turn it into a way to affect policy," she says.

Resolutions can be carried or defeated. Members may also ask for a resolution to be deferred to the board of directors for review and decision. Regardless of the outcome, Fucile says they promote engagement and boost knowledge. "We're so diverse as nurses that of course we're going to have different perspectives on issues," she says. "Testing that diversity...is really important."

Fucile, former dean of the Trent Fleming School of Nursing in Peterborough, urges her colleagues in education to get students involved in creating resolutions. This kind of teamwork, she says, can lead to valuable mentorship opportunities.

Cathy Graham agrees. The newly minted political action representative for RNAO's Kawartha-Victoria chapter, and professor at Trent has been encouraging students to draft resolutions since she began working at the university in 2003. The process helps hopeful RNs articulate a position based on evidence, develop skills around selecting, reviewing and critiquing literature, and is just "one piece of broader social justice advocacy work" inherent to nurses' roles, she says. "I think we, in education, have a responsibility to encourage students to see the relationship between (nursing and advocacy)," Graham

For important information on preparing a resolution, and the specific requirements set out by the provincial resolutions committee, see page 28. For further guidance, contact board affairs coordinator Penny Lamanna, plamanna@RNAO.ca

says. Students cannot submit a resolution without the backing of an RN, which is why Graham will gladly lend a hand.

Tapping into chapters and interest groups can also add depth to resolutions because both offer a huge well of knowledge. RNAO's provincial resolutions committee is also prepared to pitch in and help with structure and wording as resolutions go through the submission process.

Marilyn Parsons is the most recent past-chair of the committee (her term ran from 2011 to 2013). Her advice for hopeful resolution writers is simple: be clear, concise, and make sure what you're calling for is evidence-based. Start writing long before the winter deadline, she advises, as there can be a "fair bit of back and forth to get (a resolution) in appropriate form." Competing priorities often mean resolution writing can be relegated to the back-burner. Keep it top-of-mind by including it as a regular item on your chapter or interest group meeting agenda throughout the year, she says.

Parsons' final piece of advice? "It's got to be (a topic) you're passionate about."

The resolutions committee, comprised of four RNAO members, the parliamentarian and CEO, ensures resolutions and backgrounders are legal, original and fit within RNAO's mandate. It will often offer revisions to resolutions that don't meet these terms by reshaping the focus and providing recommendations to the writer(s). The committee members suggest edits to resolutions to ensure they're grammatically sound, coherent and succinct, and clearly state the objective of the submitter(s). They comb through the one-page backgrounders that accompany each resolution to make sure the information cited is supported by evidence and is clearly outlined. Nurses welcome the feedback because it ultimately leads to a stronger resolution.

Parliamentarian Riek van den Berg, who acts as an advisor on process and protocol at the AGM, says successful resolutions must: clearly identify an issue, be achievable, and concern the broader interests of RNAO's membership.

Nancy Watters was chair of RNAO's Maternal Child Nurses' Interest Group (formerly the Childbirth Nurses' Interest Group) in 2005. At the time, the group's executive team decided it wanted to better promote the evidence-based *Baby Friendly Initiative* – a set of policies and practices that have been shown to increase rates of breastfeeding.

Watters, an advocate of the initiative since the 90s, wondered what the group could do to spread the campaign's message to Ontario health organizations, including hospitals and community agencies. The team decided to write a resolution and submit it to RNAO's 2006 AGM. It was a first for Watters, but she felt confident because they decided to partner with the Community Health Nurses' Initiatives Group and the Pediatric Nurses Interest Group. "We felt that the resolution would be stronger, and the voice would be stronger as a collaborative one," she recalls.

The resolution called on RNAO to pair up with the Ontario Breastfeeding Committee to lobby the government to support the implementation of the initiative in hospitals, public health units and other community health services. It passed unanimously.

One year later, members visiting Queen's Park for the association's annual *Queen's Park Day* advocated strongly for the implementation of the *Baby Friendly Initiative* in Ontario health facilities. In 2008, France Gélinas, now the NDP's health critic, asked then-Premier Dalton McGuinty in the provincial legislature when the province would develop a breastfeeding strategy based on the *Baby Friendly Initiative*. Three RNAO board members were appointed to sit on the provincial breastfeeding services and support working group. And, in 2011, the Ministry of Health announced that implementation of the initiative would become part of the mandatory accountability agreement for all health units in Ontario.

Though these moments weren't single-handedly achieved by the 2006 resolution, "it's a huge success story for increasing awareness," says Watters. The resolution "made an important difference in the *Baby Friendly Initiative* journey in Ontario," she says. "It added momentum." **RN**

MELISSA DI COSTANZO IS THE STAFF WRITER AT RNAO.

Representatives for RNAO's chapters, regions and interest groups cast their votes on whether resolutions will be carried or defeated.

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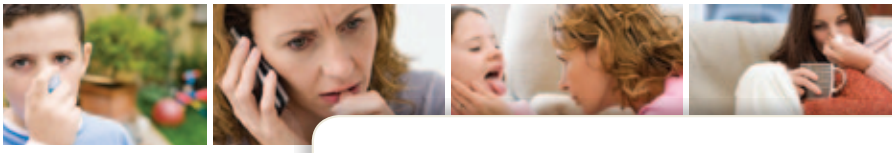

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When the new RNAO membership year begins in November 2014, Canadian Nurses Association (CNA) membership is no longer automatic. This means you have to tell us whether you want to belong to CNA when you renew your RNAO membership. We believe in a strong national body to represent registered nurses across Canada and hope you will continue to belong to CNA. Your total fees to join both CNA and RNAO remain the same as in previous years. However, if no action is taken by Aug. 20, 2014, your membership in CNA will automatically be discontinued when your RNAO membership renews (Nov. 1, 2014).*

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NOTICE OF 2015 AGM

Hilton Toronto • April 16–17, 2015

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 April 16 for the following purposes:

- To hold elections of directors as provided for in the bylaws of the association (Voting for the AGM shall be by electronic means, during April 2015. Results will be reported at the AGM)
- 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

By order of RNAO Board of Directors

Vanessa Burkoski, RN, BScN, MScN, DHA
President

CALL FOR NOMINATIONS

2015–2017 RNAO BOARD OF DIRECTORS

DEADLINE: Dec. 8, 2014 at 1700 hours

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. For the term 2015–2017, RNAO is seeking nominees for:

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RNAO BOARD COMMITTEES

Candidates are also being sought for the following vacancies:

- Member, Provincial Nominations Committee (RN vacancies)
- Member, Provincial Resolutions Committee (RN vacancies)

In accordance with RNAO policies 2014-2015, members of these board committees shall be appointed by the board of directors. Joining as a member of an RNAO board committee affords you an opportunity to become more involved and engaged in the work of RNAO.

CALL FOR RESOLUTIONS

DEADLINE: Dec. 8, 2014 at 1700 hours

See page 23 for more on resolutions

RNAO encourages individual members, chapters, regions without chapters and interest groups to submit resolutions for review and decision at the 2015 annual general meeting. Please send enquiries or materials to Penny Lamanna, RNAO board affairs co-ordinator, at plamanna@RNAO.ca

Important to note:

- resolutions must bear the signature(s) of RNAO member(s) in good standing for 2015
- a one-page maximum backgrounder must accompany each resolution (this single page will include any references). The font used must be no smaller than Arial 10 or Times New Roman 11. Margins must also be reasonable, e.g. an absolute minimum of 0.7 margin all around. All resolutions will be reviewed by the provincial resolutions committee

For clarity of purpose and precision in the wording of your resolution, we recommend it include no more than three 'Whereas'; and preferably only one, but never more than two, 'Therefore Be It Resolved that…'

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IN THE END BY MARGARET*

What nursing means to me…

For the most part, nurses care for patients who are strangers. We help those we've never met before, and will likely never see again. We're there for people during some of their toughest moments, and we care for them with the hope that they can move on with their lives and will not need us again. But nursing isn't only about caring for strangers. It's also about caring for the people who are near and dear to our own hearts. For me, nursing means the survival, development and success of my two children with special needs.

DROP US A LINE OR TWO
Tell us what nursing means to you. Email editor@RNAO.ca

My son Bradley* and daughter Amy* are twins. They arrived at 25 weeks gestation. I went into premature labour while driving home from the Hospital for Sick Children (SickKids), where I was working at the time (14 years ago) as an RN and discharge planner. Little did I realize I would return to my workplace within a few weeks, not as staff, but as the mother of a critically ill preemie. Bradley went back and forth between Women's College Hospital (where the twins were born) and SickKids during the first six months of his life. He needed emergency surgery twice for an obstructed bowel and once for a hole in his heart. Amy remained at Women's College for about four months for her care.

From the moment of their birth, I felt confident in my ability to see them through the challenges of prematurity. I have cared for their very complex medical needs both in hospital and at home. During the rough times, when monitors would sound off at the bedside, I had the knowledge, skills and judgement to not be overly worried. Looking back, had I been anxious and afraid, it would have no doubt had a negative impact on them. I was at ease when talking with doctors, nurses, and therapists, and that comfort level has continued to this day. I always had hope and believed my children would get through the early challenges, with my help.

My twins have had many difficulties with development; gross and fine motor, social skills, behaviour. Our "early years" were filled with appointments and therapy. Unexpected medical problems have occurred many times, especially for my son. But I've always drawn upon my nursing skills to see him through to a successful recovery.

Bradley and Amy will have long-term problems with cerebral palsy, brain injury, attention deficit disorder, and hearing impairment. This may sound overwhelming to some, but it's our life, our success, our determination and our resilience that make me a proud nurse. I truly believe that my children are alive, happy and thriving because I am an RN. I would not have had it any other way. **RN**

MARGARET JOINED RNAO MID-CAREER. AFTER 14 YEARS JUGGLING HER PRIORITIES AS MOM AND PART-TIME RN, SHE HOPES TO SOON RETURN TO THE WORKFORCE FULL TIME.

** Pseudonyms have been used to protect privacy*

ILLUSTRATION: TRACY WALKER

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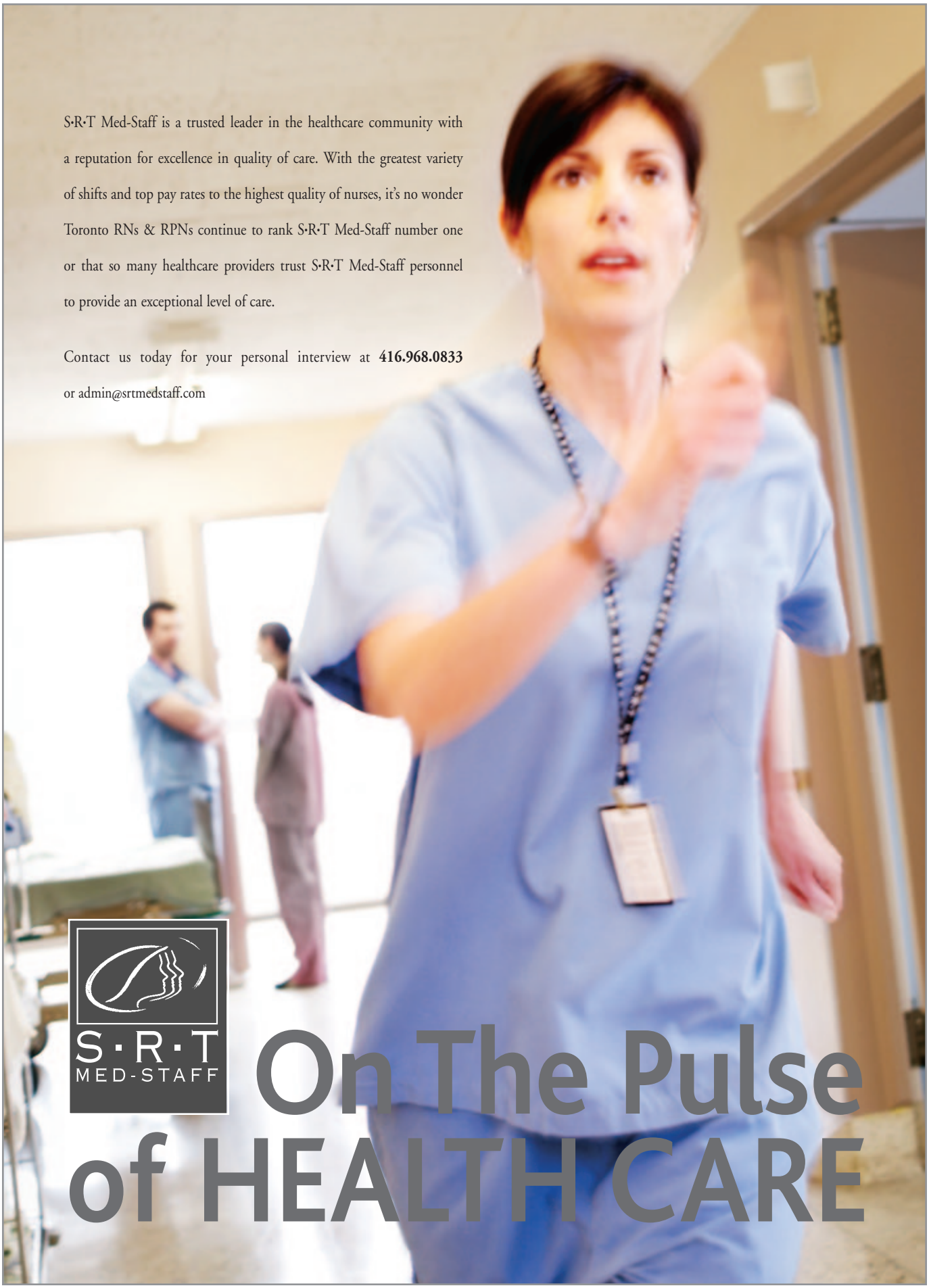

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