MAY/JUNE 2014

REGISTERED NURSE JOURNAL

A safe sleep

RNs clear up confusion on keeping babies safe as they sleep.

AGM 2014 • Legal column explores risks of leadership • Nursing Week 2014

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EDITOR'S NOTE KIMBERLEY KEARSEY

Divided discussions can enlighten

It's heartbreaking to imagine losing a child. Elyse Maindonald, one of the nurses featured in our cover story about safe sleep (page 10) says it's difficult for anyone – nurses included – to walk away from that kind of pain unscathed. Yolanda Guitar and her husband, John, lost their four-month-old boy, John Dylan, to SIDS. They generously share their story to shed light on the challenges of loss, and to make the case for consistent messaging to parents on how to keep babies safe.

In this issue, we explore the recommendations in RNAO's best practice guideline (BPG), *Working with families to promote safe sleep in infants 0-12 months of age*. They were created to help decrease the number of babies in danger while doing one of the most natural things a person can do: sleep. It's hoped the BPG will mean fewer parents have to endure the kind of pain the Guitars have endured.

The issue of dying is one that palliative care nurses understand well, but it's a difficult reality for most people to wrap their heads around. There are so many questions that come at the end of life, and often some very difficult decisions. It's no surprise, then, that debate and disagreement bubble to the surface during these difficult times. Many people hold very passionate and fundamental views on how things should play out at the end. And each person is entitled to their opinion, whatever it may be.

At this year's AGM, debate on end-of-life care was front and centre, and, at times, heated (page 16). When then President Rhonda Seidman-Carlson called the vote on a board-led resolution to engage in formal public dialogue about end-of-life issues and dying with dignity, including discussions related to assisted suicide and/or euthanasia, a majority of members acknowledged this is a vital conversation. It wasn't an easy conversation for members in May, and it won't be any easier going forward. But it's an important one. And I look forward to hearing what members have to say. **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

Humbled by this huge responsibility, and opportunity to give back

It is an honour and privilege to begin my term as RNAO president and to share my first message with you. When I assumed this important role at this year's annual general meeting (AGM) in early May, I shared a photograph taken of me 30 years ago, when I graduated from nursing school. I was so excited and proud when I received the black velvet ribbon to pin to my cap. This signified my entry into the nursing profession as a registered nurse.

Sharing that bit of history with colleagues allowed me to reflect on the history of our profession because its evolution to the present and progression into the future is rooted in policy advocacy. From the end of nursing caps to the advanced practice of nursing today, the foundation of everyday practice stems from health and nursing policy. This is confirmed in legislation and regulation that helps make our province a healthier place to live, work and play.

Some of you may know that I held the position of provincial chief nursing officer from 2007 to 2011. I was privileged to have the rare opportunity to gain knowledge and experience in the policy domain of nursing practice at a system level. During my time at the ministry, collaboration and partnership with RNAO were critical to the success of formulating sound nursing and health-care policy, and program initiatives. Why? Because the evidence-based, collective voice of over 30,000 (back then) RNAO members rang loud and clear, signaling the essential first stage of the policy cycle: the creation of a burning platform. You, as members of RNAO, articulated the issues and provided the evidence to inform sound nursing and broader health-care policy.

And you, as members of RNAO, have power in influencing the direction of system policy that guides our practice and strengthens our opportunities to advance the profession of nursing and improve the quality of care delivery for patients and families in Ontario and beyond. This is what has brought us to the strong profession that we enjoy today. This is what has enabled us to sustain the precious resource of health for the public. And, this is what will continue to enable us the privilege and responsibility of strengthening our health system for the future.

In my current role as vice president/chief nursing executive at London Health Sciences Centre, I am accountable for creating the conditions that enable nurses to excel in their practice. Policy and program initiatives driven by RNAO provide me, and all of you, with the tools and resources to make a positive difference in nursing and health outcomes. The development of RNAO's best practice guidelines, and the *Enhancing Community Care for Ontarians* (ECCO) model for system transformation (released in 2012 and revised in 2014), are just two of the many vibrant examples of how our professional association sets the bar for quality, safe care delivery, healthy work environments, and better health outcomes for all Ontarians.

> "MY KEY MESSAGE TO YOU IS THIS: YOUR RNAO VOICE IS VITALLY IMPORTANT, LISTENED TO, AND TRANSLATED INTO POLICY THAT MAKES A POSITIVE DIFFERENCE FOR OUR PROFESSION."

You are the reason I humbly accept the responsibility of RNAO president. You are my inspiration. I have witnessed and I continue to witness and experience the passion that over 36,000 RNAO members have for distributive justice. You raise important policy issues across the determinants of health. You bring insight through your practice across every domain, including clinical, education, administration, research, and policy roles. Your cross-sectoral views and innovative ideas give life to our profession, and elevate trust in members of the public who rely on us to advocate for their best interests.

My key message to you is this: your RNAO voice is vitally important, listened to, and translated into policy that makes a positive difference for our profession, patient care delivery, and the health of Ontarians wherever they are. Just like you, I am a registered nurse, and a proud member of RNAO. We are part of a voluntary, professional association committed to improving our profession and the health of the people of this magnificent province.

Personally, I can think of no better way to spend my time and energy than to give back to you, for the generous gift of spirit, enthusiasm and devotion that you have demonstrated towards our profession, patients, families and communities. I look forward to serving as your president to further catapult this great profession of nursing and make it even stronger. **RN**

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

To see (or read) the Q&A with Vanessa Burkoski, visit RNAO.ca/PresidentQandA

Medical tourism: the beginning of the end of Medicare

When this issue of the *Journal* reaches your doorstep, Ontario will have a new government. The next premier of this province – whoever it may be – will hear from RNAO about the urgent need to put a stop to medical tourism, a line of business pursued by some Ontario hospitals. As a means of generating revenue, these hospitals are soliciting patients from other countries to come to Ontario for treatment at a cost. RNAO is in staunch opposition to medical tourism because it turns health care into a commodity to be bought and sold. It destroys Medicare.

Medical tourism in Ontario dates back to 2011, when University Health Network (UHN), led by then President and CEO Bob Bell – now our province's deputy health minister – disclosed a $75 million agreement with the Kuwaiti government to provide cancer system consulting services and treatment "for a small number of Kuwaiti patients" at Princess Margaret Hospital.

Pierre LaPlante, an experienced RN and RNAO member working at UHN, approached RNAO in the spring of 2012 with concerns that four patients from Libya were receiving orthopedic surgeries in a transformed nurses' lounge at UHN's Toronto General site. LaPlante witnessed a different level of care for these patients, wondered about Ontario patients being bumped for treatment, and had concerns about the workload for nurses, which increased at night from six to seven patients per RN.

Appalled by what this could mean to the future of Medicare, I met with LaPlante and invited him to attend a subsequent meeting with Bob Bell to get to the heart of the matter. UHN's CEO was describing this initiative to the media as a "humanitarian" gesture, but his focus when meeting with us was entirely on the revenues these patients were generating for UHN. He did not consider this a danger to our publicly funded, not-for-profit system. We do, and that is why RNAO's board of directors passed a unanimous motion to do all we can to put a stop to medical tourism.

> "IF PATIENTS FROM OTHER COUNTRIES CAN COME AND PAY FOR SERVICES, THERE IS NOTHING STOPPING ONTARIANS FROM ASKING FOR — OR DEMANDING — THE SAME."

Registered nurses – in all roles and sectors – are the safety valve of Ontario's health system. Nurses care for patients 24/7, and have safeguarded Ontarians time and again throughout history. As your professional association, we listen to you, we investigate, and, when warranted, we become your megaphone, amplifying your voice, applauding positive directions such as engagement in best practices, and ringing alarm bells on issues of concern.

Kudos to LaPlante for having the courage to come forward in 2012 with his concerns about how medical tourism fundamentally endangers Medicare. We listened, investigated, and now we will ring alarm bells until Ontario closes the floodgates to international medical tourism.

RNAO brought this issue out into the open in the spring of 2013, with an opinion piece published in the *Toronto Star*. We've since addressed it in our pre-budget submission to the Ontario government, a resolution to CNA, and a letter to Premier Kathleen Wynne in partnership with the Association of Ontario Health Centres, the Association of Ontario Midwives, Canadian Doctors for Medicare, and Medical Reform Group. This spring, we also issued a joint media release urging the premier to stop medical tourism. Two days later, Health Minister Deb Matthews asked officials for "an informal review of medical tourism."

It's infuriating to imagine that hospitals would set up a program that, by design or by default, contributes to the dismantling of Medicare. If patients from other countries can come and pay for services, there is nothing stopping Ontarians from asking for – or demanding – the same. And it's impossible to imagine that respected hospitals and our government, with their army of lawyers to advise them, are not aware of the legal repercussions. Medical tourism opens the door to lawsuits driven by for-profit interest groups. They will use wealthy and/or vulnerable clients to argue that if out-of-country patients can pay their way to preferential treatment, so too should Ontarians.

Medical tourism also encourages lawsuits from foreign investors under Canada's free trade agreements, such as NAFTA, which protect against such lawsuits only "to the extent that they are social services established or maintained for a public purpose." Medical tourism undermines the "public purpose" designation.

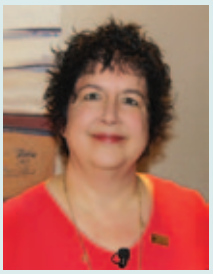
This is an issue of our already scarce health human resources being used for a parallel, for-profit system. We know this will erode the quality of the public system and public support for Medicare. And we know this is simply not the Canadian way.

This is why medical tourism must be stopped immediately. **RN**

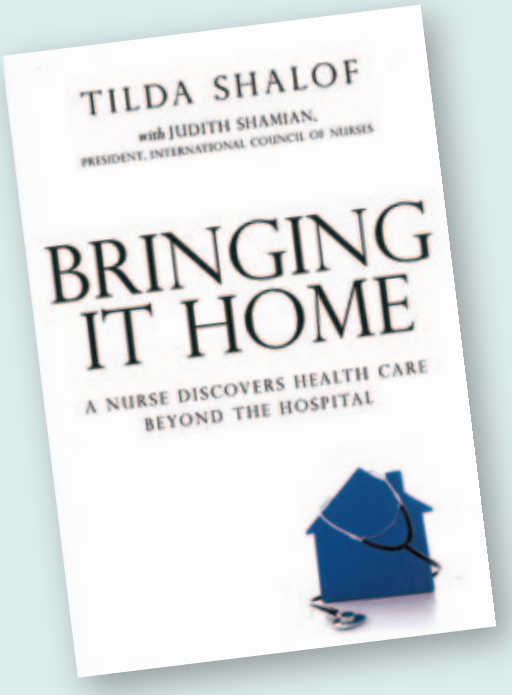
DORIS GRINSPUN, RN, MSN, PhD, LLD (HON), O.ONT, IS CHIEF EXECUTIVE OFFICER OF RNAO.

NURSING NOTES

RN author releases newest book



Two years ago, Judith Shamian, president of the International Council of Nurses, approached Tilda Shalof, a critical care nurse and bestselling author, to ask her to write her next book about home care. Shalof refused, noting she wasn't all that interested in nursing outside the hospital sector, but admitting privately that she didn't actually know much about home care. Although addicted to the pace and chaos of the hospital setting, Shamian's request got Shalof thinking, and she finally gave in to her curiosity and agreed to write *Bringing it Home: A nurse discovers health care beyond the hospital*. This is Shalof's fifth in a line of books she calls memoirs. But her research on this one was a bit different. To learn more about home care, Shalof toured Ontario and the Maritimes for eight months, visiting adult day programs, NP-led clinics, people in their homes, and community health centres catering to people living on the street. The book chronicles her discoveries. Shalof was a keynote speaker at RNAO's 2014 AGM, sharing anecdotes from the book, and her 30-year career. To find out more, visit www.nursetilda.com



Fears realized with release of study on refugee health

When the federal government announced it would begin cutting back on funding through the Interim Federal Health Program (IFHP) in July 2012, leaving refugee claimants without access to supplemental health benefits, RNs were outraged. RNAO issued an action alert, wrote an open letter to the prime minister and premier, and participated in a number of public rallies to urge the government to reconsider. Nurses' concern for the well-being of refugees, many of whom are vulnerable because they have already experienced trauma and hardship even before arriving in Canada, has come to the forefront once again with the release of a study that found admission rates for refugee children at Toronto's Hospital for Sick Children (HSC) doubled after IFHP coverage was cut. Researchers conducted a one-year review spanning six months before and after the funding cuts, and found 6.4 per cent of refugee patients in the ER at HSC actually had to be admitted. Six months later, that rate jumped to 12 per cent, suggesting parents delayed seeking care until their children became very ill. Ontario announced that, in December 2013, it would begin filling the gap left by the cuts. According to the study, HSC was left covering almost 90 per cent of the costs it incurred caring for refugee children during the research period. Although the government says the cuts will save $100 million over five years, researchers behind these recent numbers, published in *Public Library of Science Journal* (May 2014) wonder if the costs are only going to go up in the long run.

Happy and healthy transitions start and end with RNs

To ensure people continue to receive safe and effective care when they move from one part of the health system to another – whether between care providers (during shift changes), units of the same organization, or from one organization to another (hospital to nursing home) – RNAO has released its *Care Transitions* best practice guideline (BPG), and a comprehensive set of recommendations to help ensure patients don't fall through the cracks. The guideline calls for an increased role for nurses on interprofessional teams, and more effective communication between team members, patients, their families and caregivers. Gaps in care during transitions can affect everything from the medications someone is prescribed to their physical and psychological needs. The BPG is available online at RNAO.ca/BPG

MPs talk suicide prevention

This summer, Canada's MPs will be challenged to engage in conversations about suicide with their constituents as part of a national grassroots prevention campaign created by the Mental Health Commission of Canada (MHCC). The campaign, called *#308conversations* (there are 308 MPs), will address one of the greatest barriers to preventing suicide: stigma and the reluctance of society to discuss this issue openly. According to MHCC, there are 3,900 suicides in Canada each year, and 90 per cent of them can be attributed to a mental illness or mental health problem. MPs are being asked to bring together interested community members and stakeholders to share information about what is working and where the gaps in service are, allowing Canadians to learn from the experiences and ideas that are working in other parts of the country. To find out more, visit www.mentalhealthcommission.ca/308conversations **RN**

Do you have nursing news to share? Email editor@RNAO.ca

NURSING IN TH

RNs recommend comprehensive approach to fight childhood obesity

With the childhood obesity rate in Canada on the rise, RNAO recently unveiled the second edition of its *Primary Prevention of Childhood Obesity* best practice guideline (BPG). Toronto RN **Lorraine Telford** appeared on Global TV's *The Morning Show* to discuss the BPG, released May 14. Telford, one of the BPG panel leads, says the rate of childhood obesity has doubled in the last 25 years, so the panel "looked at ways to prevent the problem, rather than treat the problem." About 30 per cent of Canadian children are either overweight or obese. Telford says the new guideline recommends a comprehensive approach to fight childhood obesity, including policy changes to combat the "obesogenic" culture of sugary snacks and sedentary activities (*Global TV*, May 14). Kids who lack regular physical activity can face serious health complications in the future, says Toronto Public Health's **Carol Timmings**, the guideline panel's other lead. "Being sedentary is a risk factor not only for…obesity, but also for other diseases like cardiovascular disease (and) diabetes," she told CBC's *The National*. (May 20)

Lorraine Telford (above, left) and Carol Timmings (left) are co-leads for RNAO's revised childhood obesity BPG. They were invited by Global TV and CBC, respectively, to talk about the guideline, and what it means for children's health and wellbeing.

More staff, education needed to limit sedation of seniors

Revelations in April that Ontario nursing homes are sedating a large number of residents with antipsychotic drugs highlight the need to improve long-term care in the province.

A *Toronto Star* investigation found roughly one third of residents across 300 long-term care homes were being administered "risky drugs" such as olanzapine, quetiapine and at least 10 others. The newspaper reported the medications were often used to calm agitated or aggressive residents, though the drugs were not approved by Health Canada for elderly patients with dementia. RNAO CEO **Doris Grinspun** says the province needs to double the number of nurses working in long-term care, so staff won't have to rely on antipsychotic drugs to manage agitated residents (*Toronto Star*, April 15). "Despite the many caring personnel working in homes across the province, the sad reality is that most homes are poorly funded and inadequately staffed," she added in a letter-to-the-editor published by the newspaper (April 26). Grinspun applauded the Liberal government for its pledge to introduce 75 new nurse practitioners (NP) into long-term care, saying more NPs will "improve the quality of care residents receive, including reducing falls, the need for restraints, and unnecessary transfers to hospitals."

Oncology nurse receives cancer treatment in her own unit

A battle with breast cancer has taught oncology nurse **Cindy Barrett** about the other side of health care. The 37-year nursing veteran says receiving cancer treatment has given her a new

E NEWS

BY DANIEL PUNCH

appreciation for what patients endure. "I absolutely have sympathy for the nastier side effects. It's given me a different perspective," says Barrett, who has undergone surgery, chemotherapy and radiation while being treated by her colleagues at Royal Victoria Regional Health Centre. In October, Barrett was diagnosed with breast cancer in the same breast from which she had a tumour removed 21 years ago. She says the transition from caregiver to care receiver has been difficult, but the kindness of her fellow nurses has helped her cope. Barrett's co-worker, **Mary Ellen Love**, even surprised her with a brand new $1,000 wig when she began losing her hair due to chemotherapy. "I look at my co-workers and know we care about our patients and we care about each other," Barrett says. (*Barrie Advance*, April 1)

Cindy Barrett, left, is an oncology nurse battling cancer with the help of friends and co-workers, including Mary Ellen Love.

PHOTO: STAN HOWE, BARRIE ADVANCE

Nursing students learn what it means to be homeless and in need of care

Recent Western University nursing grad **Catherine Walsh** says some of her most valuable education came during a three-month placement at Sanctuary, a downtown London church and refuge for the city's poor. Though Sanctuary doesn't provide clinical services, Walsh said the experience changed her perspective on health care, and on poverty. "(The poor) are the same as everybody else, they just have a different set of resources," says Walsh, who now works in a Stratford ICU. Sanctuary hosts two nursing student placements each semester, and was recently honoured with the 2014 *Agency Award* from the Council of Ontario University Programs in Nursing. It was recognized for providing exceptional learning experiences to nursing students. Walsh says she was struck by how little faith in the health system many of Sanctuary's homeless clients have, adding that many of them fear they will be judged in health-care facilities. "You have to get to know every patient, regardless of what they look like...before you can make any judgments," she says. (*The Londoner*, May 14)

NP pay in hospitals beats community compensation

Ontario nurse practitioners (NP) are being drawn from community clinics to hospitals and long-term care homes, where they can earn up to $20,000 more per year. The Sudbury District Nurse Practitioner-Led Clinic – the province's first NP-led clinic – has lost four NPs to higher paying jobs over the last four years, says clinic director **Jennifer Clement**. "Unfortunately, it can come down to money," she says. "NPs realize that if they stay in their current job, they can make more money as a (registered) nurse than a nurse practitioner." NPs in community clinics earn about $74,000 to $89,000 annually, which isn't reflective of their training or scope of practice, says NP and Laurentian University professor **Roger Pilon**. "An RN who has less responsibility and a smaller scope of practice...can make even more than that," he says. NPs across the province are making the move away from community clinics, and Pilon says this can be disruptive for patients. "The patient becomes familiar and comfortable with their nurse practitioner as their primary health-care provider (and) has to start over again." (*CBC Radio Sudbury*, April 23) **RN**

Letter to the editor

Ottawa RN, **Cathy A. McKim**, *responds to an* Ottawa Citizen *article about a new book purporting to reveal slang used by health-care professionals. (April 26)*

Long-time RN has never heard insensitive hospital slang

I have worked as a registered nurse for 25 years and have never heard or used any of the terms quoted in this article and revealed by Dr. Brian Goldman, an emergency physician at Mount Sinai Hospital in Toronto, in his new book, *The Secret Language of Doctors: Cracking the Code of Hospital Slang.*

Perhaps Goldman's experience working in the ER, a uniquely stressful environment, leads him to believe that such language is pervasive, but it is not. Its use may have been more prevalent 30 years ago, but the health profession, along with the rest of society, has become more sensitive to the impact of words. Please don't leave readers with the impression that their personal and medical challenges are discussed flippantly.

a safer sleep

A new RNAO best practice guideline aims to clear up confusion on how to keep babies safe during sleep, and reduce the risk of SIDS.

BY MELISSA DI COSTANZO

PHOTO: DAVID LEWINSKI

Windsor NP Elyse Maindonald (left) chaired RNAO's safe sleep BPG panel and says nurses must be role models to new parents like Hali Sitarz and her daughter Blair.

It was early morning on June 17, 2004 when Yolanda Guitar and her husband, John, boarded a plane bound for Las Vegas.

The couple was looking forward to their four-day vacation, leaving their two kids – Emily, then two-and-a-half-years-old, and John Dylan, four months – in the hands of the babysitter they trusted with their eldest child since she was 10-months-old. Even before they stepped onto the jet, Yolanda admits: "I had a feeling...something was going to go wrong."

By early afternoon, the pair reached the MGM Grand, checked in, and poked around the slot machines until a security guard approached them. He was clutching a phone. A Toronto police officer wanted to speak to John, who was led into a back room. Yolanda, meanwhile, frantically dialled the babysitter, who didn't pick up. Instead, a police officer answered.

She doesn't remember why she asked this (a mother's instinct, maybe), but Yolanda blurted: "Did my son, did John Dylan, die?"

There was a pause. "I'm sorry to tell you that yes, he did," came the response.

"The whole casino just closed in on me," she recalls.

Before leaving for their mini-holiday, Yolanda remembers the babysitter explaining that she was going to put John Dylan, a colicky baby, to rest on his tummy. "Babies sleep better on their stomachs, and are more comfortable," she said. Yolanda had "no reason not to trust her."

Twenty-four hours later, the Guitars found themselves at Toronto's Hospital for Sick Children holding their lifeless son, who was wearing only a diaper. He died of Sudden Infant Death Syndrome, or SIDS, during a nap. The Public Health Agency of Canada (PHAC) describes the phenomenon as "the sudden death of an infant less than one year of age, which remains unexplained after a thorough case investigation," including an autopsy, an examination of the death scene, and a review of the baby's clinical history.

For Yolanda, the term is synonymous with a bad dream. Sadly, she and her husband are not the only parents who have faced this unthinkable tragedy. John Dylan was one of 84 infants who died of SIDS in 2004 across Canada, according to Statistics Canada. In Ontario, he was one of 12. Fast-forward eight years to 2012 and the number of infant deaths attributed to SIDS in Ontario was only one. According to Ontario's Office of the Chief Coroner, roughly nine years ago, it decided to more strictly define SIDS, and require very specific circumstances in order to concretely say a death was the result of SIDS. The coroner's office admits it's possible this change resulted in the dip in numbers.

Meanwhile, PHAC says between 1999 and 2004, Canada saw a 50 per cent plunge in the rate of the syndrome. The national organization says the nosedive "may be attributable, in part, to changes in parental behaviour such as placing infants on their backs to sleep, and decreasing maternal smoking during pregnancy." Efforts to raise awareness over the past decade likely contributed to these changes. The *Back to Sleep* campaign, announced by the federal government in 1999, encouraged parents to put their babies to sleep on their backs. Six years prior to that movement, Canada, in tandem with other organizations across the globe, recommended infants be placed on their backs to sleep.

Evidence suggests SIDS can occur as a result of a combination of genetic, metabolic and environmental factors, including an unsafe sleep space. Although PHAC acknowledges the actual cause(s) of SIDS is unknown, the most important, modifiable risk factors are maternal smoking during pregnancy and infants sleeping chest-down (both are discouraged).

That nap 10 years ago was the only time John Dylan was put to sleep on his belly, Yolanda says. The Toronto resident always put her children to bed on their backs. In fact, just after giving birth to Sarah, the child she had after John Dylan, she noticed her newborn had been placed on her side. Recovering from a caesarean section, Yolanda pressed a call button, and asked another nurse to put Sarah face up. "What's the hospital policy...should babies be put to sleep on their backs, sides or chest?" the new mom remembers asking the nurse, who replied: "We don't really have one. Babies should be on their back, but some nurses will do what they think is best."

This kind of inconsistency, which still exists today, was the catalyst behind RNAO's best practice guideline (BPG), *Working with Families to Promote Safe Sleep for Infants 0-12*

Months of Age. The BPG's panel of experts sifted through and analyzed years of research to create the document. "Parents will do what they see and not always what they hear," Yolanda says. The mother of three (she had two more children after John Dylan died) was on the guideline's advisory committee, a group to which the panel of experts looks for feedback and insight. "(That's why) modelling of behaviour is critical in the hospital."

Nurse practitioner (NP) Elyse Maindonald agrees, adding nurses at all levels of the health system should be aware of best practices. The chair of the BPG panel says an essential piece of the guideline urges nurses to model safe sleep practices by placing infants on their back for every sleep, unless there are medical reasons for doing otherwise. The guideline also advises nurses to reflect on their knowledge, judgement, perceptions, practices and beliefs when it comes to safe sleep environments.

"Nurses are closest to babies and mom(s)," Maindonald says. "People look up to nurses." And evidence has found nurses are key when it comes to modelling safe sleep practices.

The BPG recommends that, when it comes to sleep, babies should be snoozing alone, on their backs, in a crib that meets Canadian safety standards. The "back is best" approach applies to children under the age of 12 months. Cradles and bassinets with sides that allow air flow are also considered safe spaces. Sleep surfaces not recommended? An adult's bed, sofas, couches, armchairs, playpens, swings, strollers, slings and car seats.

John Dylan's death in 2004 was attributed to SIDS.

Caregivers are also encouraged to avoid using blankets, pillows, positioning devices, head coverings and soft toys because all can obstruct an infant's airway. "Anything that improves the infant's access to good-quality air and nothing to block the intake of that air is what (nurses) want to get across," says Maindonald. A firm mattress and fitted sheet are all that's needed, according to the guideline. Breastfeeding is also recommended as a protective factor against SIDS; smoking (before, during and after pregnancy) is not.

Maindonald reinforces the BPG's aim is to "clarify myths and misconceptions (to help) give parents the very best information that's available at this time," so they can make informed decisions.

A Windsor primary care NP, Maindonald has spent the last 25 years researching SIDS, an interest born out of personal experience: her cousin and mother-in-law each lost a child. She has worked in emergency departments and intensive care units over four decades in the profession, and says it's impossible to forget the babies who have died while she's been on shift. "It's gut-wrenching," she says. "Even as a nurse, you wonder: what could I have done differently to save that baby, to save that family from that pain?"

Maindonald anticipates RNAO's BPG will help with just that. She's optimistic its recommendations will be incorporated into nurses' daily practice, nursing school curriculums, and hospital policies.

The safe sleep BPG was officially released in February 2014, but the topic has been on the minds of nurses for a number of years. Many RNs have expressed concerns with the conflicting messages parents receive about creating a safe sleep environment for their babies.

Waterloo RN Jan Levesque was one of those nurses. Some parents told her that, when they attended prenatal classes, they were told to put infants on their backs, whereas at the hospital, they saw nurses placing babies on their sides. She felt there was a strong need for clear and consistent guidelines to support safe sleep practices.

At a time when parents are vulnerable to differences in messaging, and aren't fully aware of all the challenges of caring for a new child, Levesque says: "It's really important everybody (is) on the same page and (is) consistent."

Levesque advocated for this kind of uniformity through a variety of means, including a resolution at RNAO's 2007 annual general meeting. A working group was established to help change practices and raise awareness among providers and caregivers. RNAO also identified safe sleep practices as a guideline topic priority, establishing an expert panel in 2010 that dug into the research.

Former public health nurse Helen Tindale (she retired in 2013) sat on the BPG's panel of experts. Tindale, an early advocate for clear messaging to parents and providers, worked with moms and babies

TEST YOUR SAFE SLEEP KNOWLEDGE

A. My baby is more likely to choke while on his/her back.
☐ TRUE ☐ FALSE

B. Babies don't need to be wrapped tightly to stay warm.
☐ TRUE ☐ FALSE

C. My baby's head must be stabilized.
☐ TRUE ☐ FALSE

D. A soft sleeping surface will provide a lower risk for my baby.
☐ TRUE ☐ FALSE

E. My baby's head and arms are going to get caught in between the crib's rails.
☐ TRUE ☐ FALSE

F. Sharing the same sleep surface with my infant is safe because it's warm, calm, and he/she sleeps longer.
☐ TRUE ☐ FALSE

A. FALSE: When facing up, babies are able to turn their heads to the side, which allows regurgitated food to flow out of the mouth.

B: TRUE: It's true that babies (up to one-month-old) need to stay warm because their thermal regulators haven't stabilized. Parents can put their babies to sleep wearing layers, while being careful not to overheat the baby. If using a sleep sack, it must be properly fitted. Blankets and swaddling are not recommended.

C: FALSE: Pillows can inhibit a baby from turning his/her head to the side, which is vital if there is a need to regurgitate food or milk.

D: FALSE: Parents tend to equate soft surfaces with love and warmth. However, firm surfaces have a lower risk of SIDS. Babies can sink into a soft surface if the sheet is not pulled firm.

E: FALSE: Heads cannot fit through the rails of a crib that meets Canadian safety standards.

F: FALSE: This can lead to unintentional injury, such as asphyxiation or even unexpected death. Parents and caregivers should be supported to find alternative ways to soothe an unsettled infant, and encouraged to always place the infant on his/her own sleep surface.

Sunnybrook pediatric NP Patricia Maddalena (left) coaches new mom Daniela LaFace on safe sleep practices.

PHOTO: JEFF KIRK

BPG BREAK DOWN

All of RNAO's best practice guidelines (BPG) offer evidence-based recommendations that are grouped into three categories. The safe sleep BPG is no exception, and we explore in this full-length feature those categorized under the broad areas of practice and education. Following are further recommendations related to organization and policy changes. These provide some of the broader steps RNAO is recommending…

- advocate for education, training and resources for alternate caregivers regarding safe sleep practices for infants
- participate in research regarding morbidity and mortality as it relates to infant sleep
- advocate for improved systems for reporting and monitoring of morbidity and mortality related to infant sleep
- develop policies that support the implementation of safe sleep practice recommendations in all organizations involved in prenatal, postnatal, and community based family care.

For a more detailed list of all of the recommendations contained in RNAO's safe sleep BPG, visit RNAO.ca/bpg

for the better part of almost 40 years. For the last 25, she worked as a public health nurse in Waterloo Region. One crucial part of her role was conducting home visits. She saw blankets, pillows and stuffed toys crowding babies' sleep space, and talked to parents about the dangers these products can pose. She'd watch as grandmothers put their tiny grandchildren to sleep on their stomachs, using the opportunity to explain how things have changed. "There were no car seats when your kids were little, right?" Tindale would ask. "This is the same kind of thing. Evidence has shown car seats prevent death. We now know that…back is best for babies."

Another practice that many parents struggle with is swaddling. RNAO's guideline concludes: "there is currently no evidence on the "safe way" to swaddle an infant, and hence caution regarding swaddling should be expressed with parents/caregivers."

This traditional technique to keep infants warm can be associated with risks. For instance, wrapping babies tightly in blankets can cause overheating, which can put infants at greater risk of SIDS. A blanket can also become unravelled and cover the baby's face, increasing the risk for suffocation. If it's too tight, it can cause hip dysplasia and limit chest expansion.

During home visits, Tindale often advised parents to spend 10 minutes burping after each feeding, holding the child upright, against the chest. Then, cradle the baby and after he/she drifts off, place them on their back in the crib. "Parents need to learn how to read their baby's cues…they need practical, hands-on support…" from public health nurses and peer support groups, says Tindale.

Patricia Maddalena remembers when she began her nursing career 32 years ago. "Swaddling in the delivery room was something we all practised," she says. Now, the pediatric NP at Toronto's Sunnybrook Health Sciences Centre says "…overall, we try to impart (to caregivers) that our recommendation is not to swaddle." A member of the safe sleep expert panel, Maddalena admits educating those who have been doing it for years, or who have witnessed or heard about swaddling's perceived benefits, can be challenging.

When she encounters caregivers who are committed to swaddling, she asks: "When are you going to discontinue this practice?" She reviews the associated risks of loose blankets, especially when infants start to become more mobile. Some parents wonder how they're going to keep their youngster warm, so she recommends layers of clothing. If a sleep sack is used, it must be properly fitted. "It's imperative for families to understand what the risks are," she says. Adopting a collaborative approach is equally important, Maddalena adds, as opposed to telling parents "this is what you have to do."

"That's why she likes the title of the BPG: working with families to promote safe sleep.

Maddalena is thrilled the BPG also addresses immunizations and breastfeeding. Both have an impact on safe sleep, but can have consequences "beyond that context, as well. It's an excellent document framed in the context of safe sleep that actually helps to optimize overall development and health."

Every June 17, Yolanda Guitar and her family visit John Dylan's grave, a 15-minute drive from home. They stop by throughout the year, too, sometimes bringing food for a picnic. In the spring, they plant white daises. Not a day goes by that Yolanda isn't thinking about her son. "He was only on earth for four months," she says. "I never want him to be forgotten."

"There's a lot of guilt (and) what-ifs," she adds. "I don't want anyone else to go through this." **RN**

MELISSA DI COSTANZO IS STAFF WRITER AT RNAO.

Rough start pays off for award-winning RN

DESPITE A DECADE OF NURSING EXPERIENCE, EDSEL MUTIA STRUGGLED TO ESTABLISH HIMSELF AS AN RN IN ONTARIO.

It wasn't how Edsel Mutia pictured life in Canada when he and his wife emigrated from the Philippines in 2007. He'd read about Canadian nursing shortages, and came to Toronto expecting to continue his career as an RN. But even with 10+ years of experience, Mutia found himself unable to practise. In fact, he was told he needed another four-year baccalaureate degree just to be eligible to take his registration exam.

"I had my family to feed. Going to school isn't cheap. How could I provide (while) going to school?" Mutia remembers wondering.

Despite this once-desperate position, Mutia has established himself as a leader in Ontario nursing. He now works as a full time ICU charge nurse at Toronto's North York General Hospital (NYGH) and part time on Scarborough General Hospital's critical care response team. In 2013, he received the *Joan Lesmond Internationally Educated Nurse (IEN) of the Year Award* from the CARE (Creating Access to Regulated Employment) Centre, an organization that supports IENs as they register to practise in Ontario. The annual honour is named after the late RNAO president, who, an IEN herself, was active for many years on CARE's board of directors.

"I never expected (the award)," he says. "I keep telling them that a simple thank you and a simple smile are (enough) for me."

Mutia grew up in a village on the southern Philippine island of Mindanao. Like thousands of Filipinos before him, he discovered nursing provided the opportunity to find financial stability working abroad. Shortly after his graduation in 1994, his grandfather fell ill, so the young RN decided to stay close to home, beginning his career at a community hospital while caring for his family's patriarch.

Three things you don't know about Edsel Mutia:

1. He is a ballroom dancer who teaches lessons at a local church.
2. Tuesday is movie night, and he loves superhero films.
3. An avid tennis fan, Mutia aspires to be the next Rafael Nadal.

At the understaffed and underfunded hospital, Mutia was often responsible for up to 50 patients at a time. It forced him to be resourceful and adaptable. "When I stepped into my hospital, I had to expect it was not fully equipped," he recalls. "I just had to utilize whatever I could to provide (for) my patients."

Mutia's grandfather passed away a few years later, and he left the Philippines in 1999 for Saudi Arabia, where he worked for seven years, including five years at a humanitarian hospital in Riyadh, which was well-funded and equipped with all the newest tools and technology. Though his job had its perks, his personal life was changing. He and his wife, Tess, decided to start their family in Canada.

It can take years for IENs to obtain their registration in Ontario. In 2008, the same year Mutia applied for registration, the College of Nurses of Ontario (CNO) received nearly 1,700 applications from internationally education RNs. Mutia's initial CNO assessment required him to complete another four-year degree. Discouraged, he explored job options elsewhere, but his wife's insistence kept him here. Then, he found an ad for the CARE Centre.

He was thrilled to have access to financial support, advanced English classes geared toward nursing, and the promise of help once it came time to prepare for the Canadian Registered Nurse Examination (CRNE). With CARE's support, Mutia appealed his CNO assessment, and his registration requirements were reduced to a year's worth of courses at Toronto's George Brown College.

He passed his CRNE in 2008, and was hired to the role he still holds today at NYGH.

Over the last six years, he's gained his colleagues' respect as a passionate professional, mentor, and patient advocate. Mutia remains humble despite becoming *IEN of the Year*. He says providing excellent care just comes with the territory for nurses, adding his goal is to always ensure patients "...feel that their life is precious." **RN**

DANIEL PUNCH IS EDITORIAL ASSISTANT AT RNAO.

Annual gathering manages levity amid lively–and heated–discussion

RNAO held its 89th Annual General Meeting (AGM) in Toronto this spring (May 1-3) and almost 650 RNs, NPs, nursing students and special guests helped to mark the association's achievements over the past year. Immediate Past-President Rhonda Seidman-Carlson capped off two exceptional years of leadership by welcoming incoming President Vanessa Burkoski. Adding levity to this otherwise traditional "changing of the guard," Seidman-Carlson shared a gift with Burkoski that was given to her when she assumed the role: a tiara.

Although there were some lighter moments that made the AGM memorable, including circus performers during the opening ceremonies, there was an air of tension when members got down to business, and shared their views on a resolution brought forward by the board of directors to "...urge the provincial and federal governments to engage in formal public dialogue on end-of-life issues and dying with dignity, including discussions related to assisted suicide and/or euthanasia."

Some members were passionate in their opposition to the resolution, suggesting it contradicts the core of nursing to "do no harm," and calling for dialogue about quality palliative care before discussion about assisted suicide or euthanasia. Others vocalized their equally passionate support for open and public dialogue on an issue that has not only sparked debate among health professionals, but among Canadians. In the end, chapter, region and interest group representatives carried the resolution with an overwhelming show of cards in favour (see page 19 for the full resolution).

While the business portion of the meeting was in progress on May 2, news broke that the legislature was shutting down, and that Ontarians would head to the polls on June 12. In the weeks preceding the AGM, rumours swirled of a possible election, but that didn't seem to deter politicians from attending the opening ceremonies. Among them: Ontario's Health Minister Deb Matthews, Conservative MPP Bill Walker, and NDP MPP and Health Critic France Gélinas.

RNAO CEO Doris Grinspun and then President Rhonda Seidman-Carlson respond to questions and ease concerns during the debate over the board's resolution to engage in formal public dialogue about end-of-life issues, including dying with dignity.

Vanessa Burkoski became RNAO's 53rd president on May 2, and took a walk down memory lane with a photo of her graduation. She reflected on just how much the profession has changed since she first became an RN, and as a result of RNAO's policy advocacy.

Leslie Hirst, Immediate Past-President of the Palliative Care Nurses Interest Group, was one of many members who approached the microphone to express their views on the board of directors' resolution to open dialogue among nurses and members of the public about dying with dignity.

AGM dignitaries include past presidents

Each year, RNAO past presidents are invited to play a role during processions at the AGM opening ceremonies and president's banquet. Their involvement is tradition, and their integral role in the festivities is embraced. Featured here are (L to R, back row): Irmajean Bajnok (1977–79), Rhonda Seidman-Carlson (2012–14), Charlotte Noesgaard (1997–98), Doris Grinspun (CEO, 1996–present), Wendy Fucile (2008–10), and Mary Ferguson-Paré (2006–08). Seated (L to R) are: Valerie Smith (1993–94), Shirley Wheatley (1981–83) and Elsabeth Jensen (1989–90).

Board of Directors 2014–2015

Front row (L to R): Rhonda Seidman-Carlson, Immediate Past-President, Vanessa Burkoski, President, Doris Grinspun, Chief Executive Officer
Second row (L to R): Jackie Graham, Region 8 Representative, Kelly Booth, Member-at-Large, Nursing Education (forward), Patricia Sevean, Region 12 Representative, Stephanie Blaney, Region 11 Representative, Aric Rankin, Region 3 Representative, Veronique Boscart, Region 4 Representative, Marianne Cochrane, Interest Groups Representative
Back row (L to R): Nathan Kelly, Member-at-Large, Socio-Political Affairs, Deborah Kane, Region 1 Representative, Denise Wood, Region 9 Representative, Claudette Holloway, Region 7 Representative, Janet Hunt, Region 2 Representative, Cheryl Yost, Member-at-Large, Nursing Practice, Carol Timmings, Member-at-Large, Nursing Administration, Rebecca Harbridge, Region 5 Representative, Paula Manuel, Region 6 Representative, Una Ferguson, Region 10 Representative
Absent: Angela Cooper Brathwaite, Member-at-Large, Nursing Research

For more information about RNAO's evidence-based advocacy efforts, financial statements, and membership numbers from the past year, take some time to flip through the Annual Report at RNAO.ca/2013AnnualReport

Results of RNAO's One member, One vote

For two weeks in April 2014, all members had the opportunity to vote electronically on several RNAO governance issues. This is the second year RNs have been given this important role, and 1,192 took the time to cast online ballots (compared to 700 voters in 2013).

An amendment to the RNAO bylaw related to members calling a special general meeting, proposed by the board of directors, was approved. Members also voted in favour of approving KPMG to audit RNAO's financial statements again this year, and passed (almost unanimously) the board's resolution to decrease RNAO's fee.

Online ballots also included the names of members in the running for available positions on the board of directors. The successful candidates were revealed during the business portion of the AGM. Cheryl Yost was elected Member-at-Large, Nursing Practice, and Marianne Cochrane was re-elected as the board's Interest Groups Representative.

Acclaimed candidates who will now serve on the board include: Kelly Booth, Member-at-Large, Nursing Education; Angela Cooper Brathwaite, Member-at-Large, Nursing Research; Nathan Kelly, Member-at-Large, Socio-Political Affairs; and Stephanie Blaney, Region 11 Representative.

Irene Molenaar was elected as a member of the provincial resolutions committee, and Victoria Pennick was acclaimed as a member of the provincial nominations committee.

(Top left) Members of RNAO's Peel chapter, host of the 2014 AGM, wore blue T-shirts to identify themselves as ready and willing to provide guidance or information throughout the AGM. Volunteers at the opening ceremonies included (L to R) Jo-Anne Wilson, Hataichanok Sae Yang, Sean Noronha, Angela Apresto, Tessa Shelvey, and Ancilla Barco.

(Bottom left) (L to R) Debra Bournes, Provincial Chief Nursing Officer, Judith Shamian, President of the International Council of Nurses, and Irmajean Bajnok, Director of RNAO's International Affairs and Best Practice Guidelines Centre, take time out of their otherwise busy schedules to socialize during the opening ceremonies.

(Top right) Nursing students are invited to learn more about RNAO by doing a placement in the days leading up to the AGM. They attend meetings at home office before the event, and are part of the activities the day of the AGM. RNAO project co-ordinator David McChesney (back left) leads the initiative, and this year welcomed: (L to R, back row) Patricia Julian, Justine Von Niessen, Peter Su, Tirtha Bhattarai, and (L to R, front row) Faye Lissa Marie De Vera, Yessica Rivera Belsham, Rona Khudayar, Peyman Sharifi-Tehran, and Ioana Gheorghiu.

(Bottom right) Minister of Health Deb Matthews (right) socializes with RNAO members during the opening ceremonies, and stops for a photo with board member Marianne Cochrane (centre) and Sepelene Deonarine.

NDP Health Critic France Gélinas joined her colleagues from the Liberal and Conservative parties as special guests at the opening ceremonies. She brought greetings to nurses on behalf of party leader Andrea Horwath.

Many politicians attend the AGM opening ceremonies to connect with RNs, and this year was no exception. Bill Walker (right), the Conservatives' Children and Youth Services Critic, brought greetings from his party during the keynote presentations on May 1. Also on hand was NDP MPP Paul Miller, who chatted with nurses before the formal procession and ceremonies began.

Members support two resolutions at 2014 AGM

Individual RNAO members, chapters, regions without chapters, interest groups, and the board of directors can submit resolutions for consideration at the AGM. These resolutions give RNAO a mandate to speak on behalf of all members. They touch on pressing nursing, health and social issues that affect not only members' practice, but the public as well. RNAO members represent many facets of nursing within the health system, and play an important role in ensuring the voices of nurses are not only heard, but also reflected in government health policy. Here is a recap of the 2014 resolutions.

RESOLUTION #1

RN voice in national discussion regarding end-of-life care

Submitted by RNAO Board of Directors

THEREFORE BE IT RESOLVED that RNAO urge the provincial and federal governments to engage in formal public dialogue on end-of-life issues and dying with dignity, including discussions related to assisted suicide and/or euthanasia; and

BE IT FURTHER RESOLVED that the following principles be considered when discussing assisted suicide and/or euthanasia:

- Personal autonomy and justice are fundamental principles
- Ensuring timely access to evidence-based palliative care must remain a top priority
- The government must reject calls for involuntary euthanasia
- Assisted suicide and/or euthanasia must never be considered within the context of cost savings
- Procedural safeguards must be enacted, including:
  - Restricting assisted suicide and/or euthanasia to competent adults with terminal illness;
  - Requiring that requests for assisted suicide and/or euthanasia be initiated by the person seeking the service and would be subject to a thorough review process that includes: independent confirmation on terminal illness; determination of capacity by a mental health-care professional (with appeal to the Consent and Capacity Board); providing access to all reasonable alternatives and establishing a waiting period.
- The practice of assisted suicide and/or voluntary active euthanasia must be restricted to professionals who have sought designated education and training.
- No health professional or organization should be required to participate in assisted suicide and/or voluntary active euthanasia.
- A provincial monitoring and reporting system must be developed, including a process for responding to complaints.

➤ **CARRIED**

RESOLUTION #2

Education for nurses

Submitted by Staff Nurses Interest Group

THEREFORE BE IT RESOLVED that RNAO examine and transform the content and delivery of current educational programs to better suit the needs of staff nurses and all nurses at the point-of-care; and

BE IT FURTHER RESOLVED that RNAO explore sources of funding for developing future educational programs that would meet the needs of all nurses related to costs, accessibility and the CNO Professional Standards.

➤ **CARRIED**

To find out more about submitting a resolution, and the process for approval by the provincial resolutions committee, watch the summer issue of *Registered Nurse Journal* for an in-depth and practical feature.

Peer recognition makes RNs proud

Each year, RNAO recognizes exceptional RNs – and sometimes non-RNs – for their leadership in administration, education, research, clinical excellence, political action, and mentorship, and for their commitment to their professional association at the local, regional, provincial and national levels. This year's roster of winners crosses a number of sectors, and each winner has their own unique set of remarkable skills. Award recipients were honoured on May 2, during the afternoon portion of the AGM and at the president's banquet in the evening.

Congratulations to all of this year's winners. To read their individual profiles online, visit RNAO.ca/2014recognitionawards

Sheila O'Keefe-McCarthy (left) and Rachelle Bergeron received recognition awards during a leadership luncheon for students on May 2. O'Keefe-McCarthy, who won the *Leadership Award in Student Mentorship*, said becoming a mentor was just a natural progression. Bergeron took home the *Student of Distinction Award*, saying RNAO membership has helped her to find her voice and solidify her passion for advocacy.

◀ RNAO recognition awards were handed out at the president's banquet on May 2. A number of the individuals pictured at left represent Toronto Public Health, which won the *RNAO in the Workplace* award, including Mae Tao (holding the award, centre).

RNAO CEO Doris Grinspun and Provincial Chief Nursing Officer Debra Bournes (second and third from left, respectively) shared in the celebration with award winners, including Anne LeMesurier (far right), who received the *President's Award*, and Bahar Karimi (second from right) who took home the *HUB Fellowship*.

Also honoured were (second from right, back row) Michael Creek as an *Honoured Friend of Nursing*, (third from right, back row) Sheryl Bernard with an *Award of Merit*, and (fourth from right, back row) Wendy Fucile with a *Lifetime Achievement Award*. Absent is Jo Hoeflok, this year's second recipient of an *Award of Merit*, who was unable to attend the banquet.

Peel chapter, host of the 2014 AGM, is a four-time winner of RNAO's *Chapter of the Year*. Although there is an extremely active and engaged executive of 20, four members represented the group at the awards ceremony. They are (L to R) Tessa Shelvey, Anita Tsang-Sit, Karen Hilliard and Maria Tandoc.

The Staff Nurse Interest Group's (SNIG) innovative use of web and social media, which has brought membership together and established SNIG on the cutting edge of RNAO, is what secured its win as *Interest Group of the Year* for 2014. Representing the group during the awards presentation are executive members (L to R) Una Ferguson, Kirsten Bildfell, Brenda Hutton, Christine Kent and Paula Manuel.

DEBBIE TOPPOZINI & CAROL MAXWELL

Debbie Toppozini (top) accepted the award for *Leadership in Nursing Administration* on behalf of herself and **Carol Maxwell** (below), best friends who job shared for more than two decades in Sioux Lookout.

Carmen James Henry was recognized with the *Leadership Award in Nursing Education (Academic)* as a result of her reputation as a passionate educator who challenges her students to grow personally and professionally.

CARMEN JAMES HENRY

LISA LUN

Lisa Lun received the *Leadership Award in Nursing Education (Staff Development)* for promoting best practice standards and encouraging her staff to participate in various educational opportunities.

This year's *Leadership Award in Nursing Research* went to **Cheryl Forchuk**, a professor and associate director of nursing research at London's Western University who says she moved from clinical work into research so she could improve nursing practice.

CHERYL FORCHUK

LORRAINE TELFORD

The 2014 *Leadership Award in Political Action* went to **Lorraine Telford**, who believes that significant social change takes time and can be daunting, but that brave health professionals have made a difference.

POLICY AT WORK

What will Ontario's health system look like in the future?

A snapshot of the future was unveiled at Queen's Park on April 30, during a media conference organized by RNAO. For the past two years, board members and staff have been working on a comprehensive look at what the nursing profession and the province's health system should look like by 2030. *Charting a course for the health system and nursing in Ontario* examines every aspect of the health system, from how care is delivered, to who delivers it, and where.

There are recommendations for the five largest sectors in the system: public health; primary care; hospital care; home care; and rehab, complex care and long-term care. The vision emphasizes a shift from the current model, which is largely focused on illness care, to one where greater attention is given to health promotion, disease prevention and managing chronic conditions.

Understanding that change cannot happen overnight, RNAO's blueprint contains recommendations that can be implemented immediately, others within the next five years, and some in the longer term. There are two versions of this vision. One is aimed at members of the public. The other lists concrete recommendations and is aimed at politicians and policy makers.

Interested in learning more about RNAO's blueprint for the future? Check out www.vision.RNAO.ca

(L to R) RNAO CEO Doris Grinspun, Immediate Past-President Rhonda Seidman-Carlson, and President Vanessa Burkoski host a media conference in late April to unveil the association's vision for the future of health care.

Take your politician to work

In early May, when Kathleen Wynne called the election, RNAO decided to take a different approach to one of its key Nursing Week political events. For the past 14 years, members have invited politicians to visit their workplaces to experience first-hand the satisfaction and the challenges of delivering health care in various practice settings.

Since politicians running for re-election are technically not members of provincial parliament (MPP) until they are re-elected, RNAO re-branded the association's longstanding *Take Your MPP to Work* event as *Take Your Politician to Work*. Invitations were sent to all four major parties. Over 45 visits had been organized by the end of May, with more expected.

See page 23 for photos of Nursing Week events, and visit RNAO on Facebook for more.

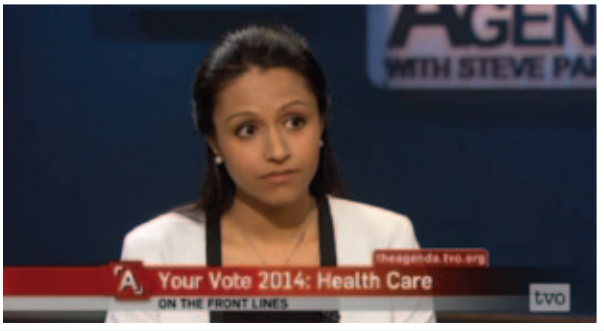
Health policy resolutions for CNA to consider

When RNAO President Vanessa Burkoski and CEO Doris Grinspun head to Winnipeg this June, they will be armed with three health policy resolutions to be tabled during the Canadian Nurses Association's (CNA) annual general meeting (AGM). One resolution requests that CNA advocate against initiatives that market Canada as a destination for medical tourism. In recent years, a number of health-care organizations have entered into lucrative partnerships with other countries, exchanging access to care for money (see page 6). The resolution shows how medical tourism threatens the sustainability of the country's universally accessible and publicly funded system.

RNAO is also asking CNA to take action to prevent new, for-profit plasma collection centres from setting up in Canada. In November 2012, a company called Canadian Plasma Resources submitted an application to Health Canada to operate several pay-for-plasma clinics in Ontario. Concern about the safety of the blood supply goes back decades, when thousands of Canadians became infected with HIV and Hepatitis C due to blood and plasma that wasn't properly screened from paid donors. Justice Horace Krever led a public inquiry, and recommended blood be considered a public resource, and that donors not be paid. Ontario introduced legislation to ban such payments, but the bill was not passed before the election was called.

A third resolution urges CNA to join with other civil society groups to oppose the federal government's *Fair Elections Act*. RNAO believes the act diminishes the authority of the country's chief electoral officer, restricts basic voting rights, and expands the influence of those who make private donations to parties. **RN**

NURSING WEEK 2014



RNs in the media ◄

In addition to news coverage of RNAO's obesity best practice guideline (BPG) in *Nursing in the News* (see page 8), RNAO members spoke to the media during Nursing Week about other health and nursing issues. TVO's *The Agenda with Steve Paikin* hosted a live chat with frontline health-care workers about health care as an issue during the election. RNAO members Michelle Acorn, a nurse practitioner at Lakeridge Health, and Kamini Kalia, an advanced practice nurse at Toronto's Centre for Addiction and Mental Health (above left), were among the guests. CHEX TV's *HealthWatch* program visited nurses in Kawartha-Victoria to learn more about the local chapter and what issues are important to RNs. Claire Hanlon (below left) spoke about the need for better home care, and opposition to the privatization of health services. Beryl Cable-Williams was also featured in the piece, and spoke about how RNAO's Kawartha-Victoria chapter provides a forum for local RNs to socialize and network.

Huron nurses get update ▲

Nurses with the Huron County Public Health Unit pose with Nancy Peroff-Johnston, a senior nurse consultant in the Ministry of Health and Long-Term Care's Public Health Division (inside row at right, third back, in glasses). Peroff-Johnston presented to the group for Nursing Week, sharing news on government initiatives related to infectious disease and social determinants of health. She also talked about the new chief nursing officer positions in public health, and how they're being implemented, and touched on some concerning trends in the sector, including replacing public health nurses with health promoters.

Take your politician to work

During Nursing Week, Premier Kathleen Wynne stopped by the West Park Healthcare Centre in Toronto May 16, where she, the Don Valley West candidate in the provincial election, toured the centre and met with staff and clients. Here, Wynne (centre) poses with Etobicoke-North Liberal candidate Shafiq Qaadri (far left), RNAO CEO Doris Grinspun (second from left), West Park President and CEO Anne-Marie Malek (second from right), and York South-Weston Liberal candidate Laura Albanese (far right).

Progressive Conservative Party Leader Tim Hudak greets three nurses from Ottawa's Children's Hospital of Eastern Ontario (CHEO) during a May 22 visit as part of RNAO's *Take Your Politician to Work* initiative. For the past 14 years, RNAO has invited politicians to join RNs at work for Nursing Week to get a first-hand look at health care in Ontario, and discuss the province's health needs.

NDP MPP candidate Cheri Di Novo (left) paid a visit in May to RNs at Toronto's Four Villages Community Health Centre. RN Jessica Connor talked to her about what she would

Celebrating BPSOs ▼

Owen Sound's Grey-Bruce Health Unit (left) and London's Victoria Hospital (below) were two of three Ontario sites to host media conferences during Nursing Week, demonstrating how best practice guidelines are helping to enrich the care nurses provide to patients, and celebrating each site's designation as a Best Practice Spotlight Organization. Grey-Bruce hosted a gathering of staff and media, attended by Sue Sweeney, RNAO long-term care best practice co-ordinator for the Southwest LHIN (above, left), and Irmajean Bajnok, director of RNAO's International Affairs and Best Practice Guidelines Centre. Joining the festivities at London Health Sciences Centre (LHSC) were RNAO CEO Doris Grinspun (below, third from left) and RNAO President Vanessa Burkoski, who is LHSC VP/Chief Nursing Executive (centre, in cream).

Collecting for a cause ▲

Each year, in honour of Nursing Week, Region 10 RNAO member Bea Osome (second from right) organizes a food drive. Staff at Garden Terrace, a nursing home in Kanata, collect donations. Pictured (L to R) are PSWs Amarjit Jaswal and Rita Josol-Cutler, Annik Donzil, director of care, Ednia Collier, a private sitter, Osome, and RN Nargis Morad.

To see more photos from Nursing Week, visit **www.facebook.com/RNAOhomeoffice** to check out the gallery.

change in the health-care system if she had the opportunity. They also focused on some of the barriers RNs and NPs face when it comes to practising to their full scope.

Thunder Bay plays host to past-president ▲

RNAO Immediate Past-President Rhonda Seidman-Carlson (left) celebrated Nursing Week with a visit to Thunder Bay Regional Health Sciences Centre, where she delivered a keynote address about healthy work environments and bullying. She toured anti-bullying information booths, speaking to nurses, including Chad Johnson, a trauma CNS (right).

Toronto Star Nurse of the Year ▲

RN Lisa Gillespie (top, third from left), who launched a harm reduction program and works in public health in Woodstock, received the 2014 *Toronto Star Nightingale Award* for Nurse of the Year at RNAO's Nursing Week Career Fair May 16. Honourable Mentions in the annual competition were (top, from left) James Mastin and Captain Colleen Grebstad. RNAO Director Irmajean Bajnok (third from right), CEO Doris Grinspun and the *Toronto Star*'s Bob Hepburn congratulated the winners for their achievement.

Nursing Week declared in Sudbury ◄

Sudbury Mayor Marianne Matichuk (right) officially proclaimed May 12–16 *Nursing Week* in Greater Sudbury. She attended the RNAO Sudbury chapter event May 12, accompanied at the podium for the official declaration by chapter president Lise Thomas (left) and chair of Sudbury's *Nursing Week* committee, Paul-André Gauthier.

Creative kids' view of nursing

RNAO's Halton chapter called on youngsters this Nursing Week to "show" what nursing means to them. School children submitted their creative artwork to the chapter's first-ever art competition, and three were selected. Burlington Grade 1 student, Sophie Inara Alidina, won in the primary category (Grades 1–3) (left), Oakville Grade 4 student Zakir Kassam won in the upper primary category (Grades 4–8) (right), and Waterloo Grade 9 student Keauna Persuad won in the secondary category (Grades 9–12) (far right). Each child walked away with a small gift for their efforts, and bragging rights as winners of the first-ever Creative Kids competition.

LEGAL COLUMN

BY JANE LETTON

The risks of leadership

PROTECTING YOUR REGISTRATION WHILE TEACHING, SUPERVISING OR ACTING AS A PRECEPTOR.

Preparing the next generation of nurses to enter the profession requires the dedication of experienced nurses to teach, supervise and act as preceptors. And yet, there are legal risks that educators need to consider in order to ensure the protection of their registration while providing leadership and guidance.

In the clinical setting: Be careful what tasks you assign

Whether providing guidance to a student, a new grad, or a nurse new to a specialty, RNs who act in a supervisory role are obligated to be aware of the competencies of those under their supervision. They must ensure assignments are appropriate for the person's knowledge, skill level and judgment. Supervisors must assign and re-assess workloads and duties accordingly, and provide ongoing communication and resources for support. If an experienced RN in a leadership role fails to do this, she/he may find themselves liable if something goes wrong.

In one Canadian legal case, an infant suffered oxygen deprivation during birth, which caused severe brain damage and resulted in numerous physical disabilities. A junior nurse was assigned to the obstetrical unit at the time. Her team leader put her in charge of fetal heart monitoring, even though she had low test scores, performance issues, and was struggling with the number of patients she had to manage. The team leader ignored the junior nurse's requests for help.

In this case, the team leader did not appropriately supervise, and was liable. She was aware of the junior nurse's difficulties handling the workload, and did nothing to provide relief. She also was not physically present. Whether acting as a nurse educator or supervising inexperienced nurses, the message to RNs is clear: the safety of the client comes first.

> "RNs who act in a supervisory role are obligated to be aware of the competencies of those under their supervision."

According to guidelines put out by the College of Nurses of Ontario (CNO), experienced nurses who are educators, supervisors or preceptors are "accountable both for sharing appropriate nursing knowledge and for maintaining safe, effective, and ethical client care within the standards." Acknowledging novice nurses and students may make errors, CNO takes the context of each situation into account. The guidelines state that experienced RNs in these roles are not accountable for a novice nurse or student's actions "...if the nurse has fulfilled her/his responsibilities as outlined (e.g. learning plan, appropriate supervision) and if the nurse had no way of knowing that the error was going to occur."

I urge all RNs to read that sentence carefully. There are two key components: 1) the nurse must provide an appropriate learning plan and supervision, and 2) the nurse could not foresee the error.

As a preceptor: Ensure competency

When a nurse takes on the role of preceptor, it is essential that she/he is aware of the competence of their preceptee. While the preceptor may rely on information provided by educators or other managers, there remains an obligation to determine from a preceptee the limits of their knowledge and skills. Ongoing and clear communication of instructions, problems, concerns, policies and procedures is essential to the relationship, and to ensure safe practice.

In order to minimize the risk of legal liability, a preceptor must assign appropriate tasks that use current methods, and provide adequate supervision that allows for the opportunity to discuss problems and concerns if they arise.

The duty to accommodate

Novice nurses or students who have a physical or mental health disability have the right to be accommodated if that accommodation does not jeopardize patient safety or disrupt service delivery. For nurse educators, the duty to accommodate can arise in the classroom setting. Students may receive special consideration around testing methodology and placements. In the clinical setting, there may need to be physical accommodations, such as modified working hours, provision of assistive devices/equipment, or limitations on lifting. Regardless of the setting, nurse educators and supervisors must consider all available options for accommodation, and base their decisions on facts, not assumptions, about an individual's abilities.

Ensuring those with disabilities are able to fully participate in their studies and practice through appropriate accommodation is an obligation set out in the *Ontario Human Rights Code*. **RN**

Jane Letton is a lawyer at Ryder Wright Blair and Holmes in Toronto. She has been representing members of RNAO's Legal Assistance Program (LAP) for four years.

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Happy Nursing Week to all nurses,

and endless thanks for the work you do.

To all the amazing nurses and nursing students in Ontario: an endless thank you for the vital work you do. You nurse people at every stage of their lives: from the moment a baby is born, to a person's last breath. Your knowledge and compassion help relieve the pain and suffering of those who live on the streets, those who seek refuge in shelters, those who come to primary care clinics or hospitals, those who wait for you in their homes, or those who need you in their nursing homes. Your expertise as clinicians, administrators, researchers, educators and policy makers is central to continue strengthening health and health care in Ontario. Your courage to advocate, and your commitment to always put Ontarians' needs at the centre of what you do, make you their safety valve and that of the health-care system.

As we mark National Nursing Week, we extend our deepest gratitude to you for choosing to be a nurse. You are helping to make Ontario a healthier place to live, work and play in times of health and in times of illness.

Vanessa Burkoski, RN, BScN, MScN, DHA
President, RNAO

Doris Grinspun RN, MSN, PhD, LLD (hon), O.ONT.
Chief Executive Officer, RNAO

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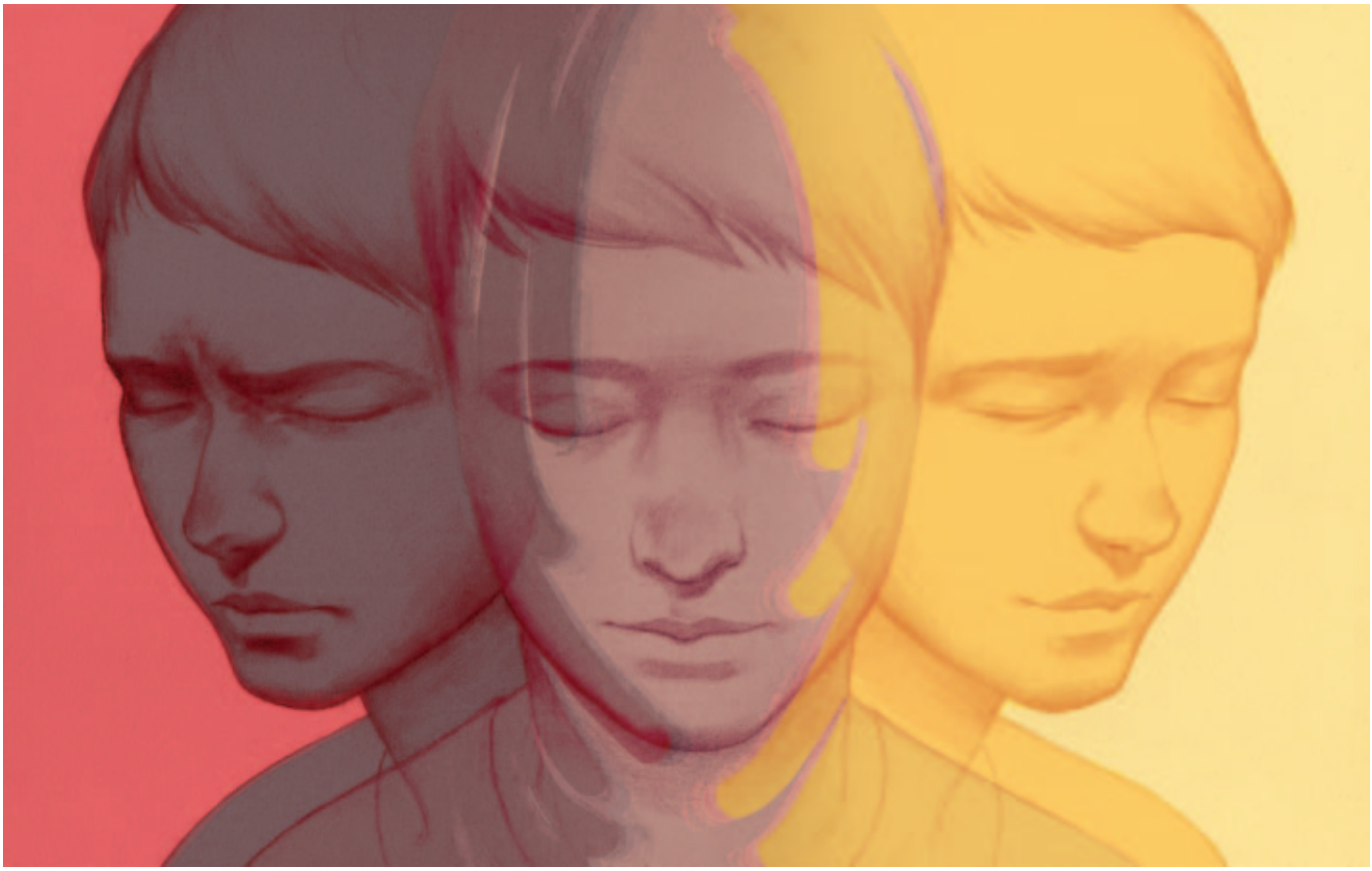
IN THE END

BY LAUREN MINIELLY



What nursing means to me…

As nurses, we are so often focused on providing care that we forget what it is like to be a patient. I always believe that I provide compassionate, sensitive, client-centred care. But, is that always what my patients experience? Are nurses guilty of helping too much on occasion, or being too insistent on things we know are in a patient's best interest?

Few things in life compare with a major trauma. As nurses, we witness these sometimes life-changing moments all too often. To survive psychologically, we compartmentalize and detach ourselves. At one time, every nurse has thought: "I just need to get this done." Some patients see us as angels. To others, we can appear irritated, frustrated or paternalistic.

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

I recall one motor vehicle accident, when a young woman was brought into the ER, noncompliant at times. She was asked repeatedly if someone could call to notify her parents of the situation. She refused, which the nurses in this small community hospital were unable to believe or accept.

In the midst of the hectic ER, nurses attempted to insert intravenous lines to prepare the woman for tests, while also suctioning as she coughed up blood. They were too focused on their tasks to explain or reassure. The team decided a catheter was necessary to monitor output for signs of internal organ damage. The woman adamantly refused. The team cut off her ruined clothing and carried on with the intervention, stating necessity.

After hours of similarly difficult exchanges, the young accident victim was transferred to the ICU. Sitting on the side of the bed early the next morning, she and her husband could hear health providers discussing her personal life in the hallway, suggesting that the couple was far too young to be married.

This young victim recovered, and wanted to be discharged. But her perspective of the health-care system was changed forever.

It can be so simple to become carried away in our practice, especially in critical situations. Nurses want to help, and that passion drives us to make a difference. But we need to make the right difference to our patients.

To me, nursing is changing the world, at least for that one moment, to that one person. It's not simply a job or something we can turn off at the end of a shift. We need these kinds of difficult patient experiences to remind us of the difference we make. Every day, I ask myself: "How do I want this patient today to perceive me, and to perceive nursing?" **RN**

LAUREN MINIELLY WORKS IN PALLIATIVE CARE IN A SMALL COMMUNITY IN SOUTHWESTERN ONTARIO.

ILLUSTRATION: ASHLEY MACKENZIE

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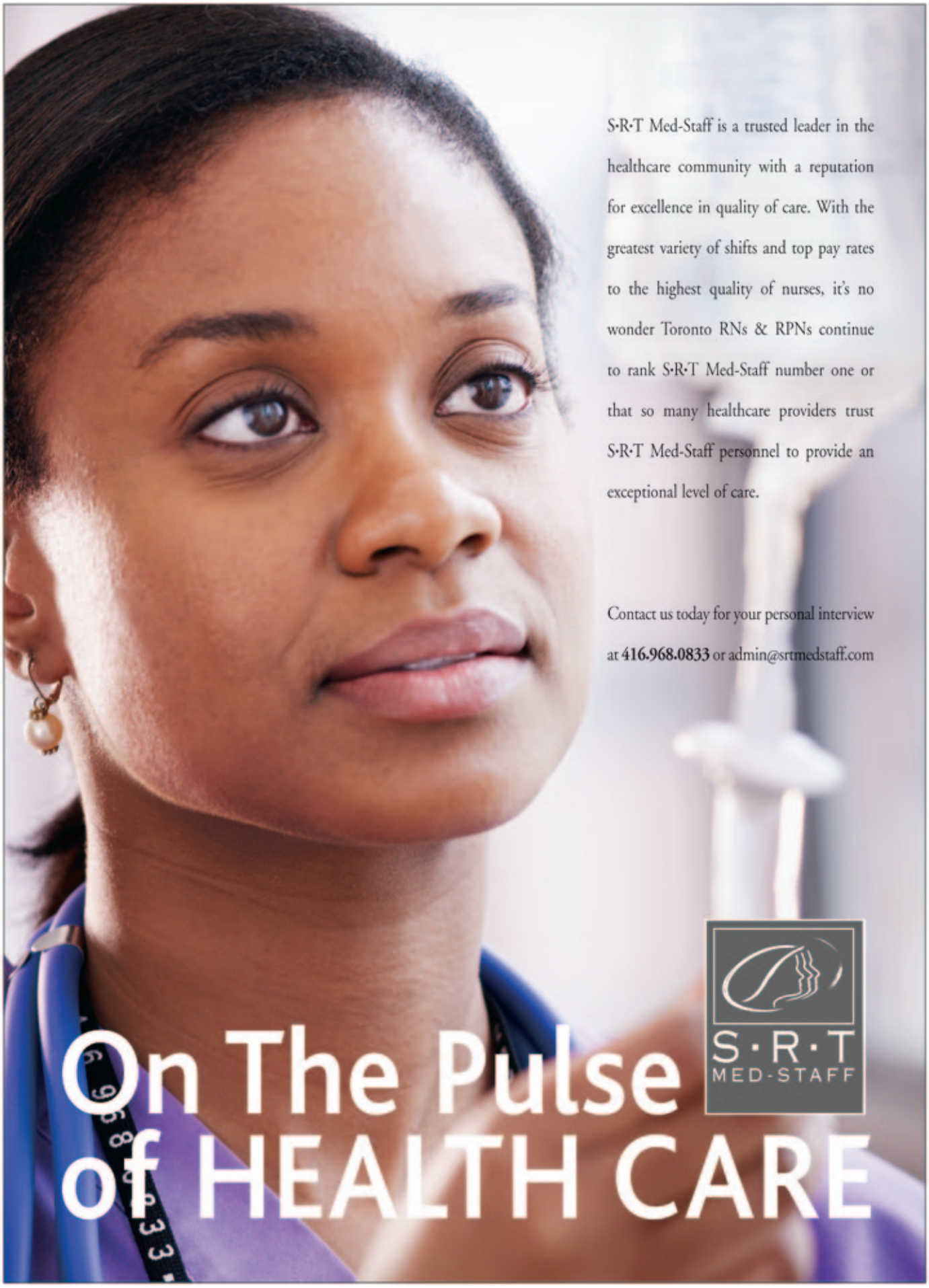
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