SEPTEMBER/OCTOBER 2012

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VOL. 24, NO. 5, SEPTEMBER/OCTOBER 2012

REGISTERED NURSE JOURNAL

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EDITOR'S NOTE KIMBERLEY KEARSEY

Changing colours, changing lives

Fall is a fitting time to talk about fresh starts, for Canadians and non-Canadians alike. This country is home to hundreds of thousands of individuals who have left their birthplaces for the promise of a happier and healthier life. In this issue, we delve into the federal government's decision to limit health care for refugees (page 12), and explore the impact this will have on their wellbeing.

Continuing on this theme of fresh starts, we bring you stories of nursing students who are discovering the value of RNAO membership right from year-one. Thanks to committed volunteers such as Katherine Gilbert and Marianne Cochrane (page 22), Ontario's future RNs are discovering just how RNAO can help them find their voice.

Carol Deimer (page 17) is helping a different demographic find its voice. She works with obese children, encouraging them to build a better future. She was also invited to participate in a Ministry of Health expert panel tasked with determining recommendations for lowering childhood obesity rates by 20 per cent in five years.

It's an ambitious goal, and certainly a worthwhile one. After all, what's wrong with setting high expectations? That's what RNAO does each year at membership time, relying on star recruiters like those featured on page 18 to boost interest in the work of the association.

Thanks to their enthusiasm – and the enthusiasm of many other members – we can effectively speak out for nursing, and speak out for health. **RN**

Membership: a force for positive change

For many of us, fall signifies a new year because it marks the end of summer and the start of a new school year. For me, it's a time to reflect. And for RNAO, fall reflections always focus on membership. Being a member of something connotes the concepts of participation, belonging, fellowship and enrollment. For me, RNAO membership has been all these things and more.

When I moved to Ontario from Quebec, I knew little about the health-care system in Ontario, and much less about the issues facing nurses and other health-care providers. The College of Nurses of Ontario helped me appreciate the standards and expectations required for registration. However, it was connecting with RNAO that helped create my sense of a 'professional' home.

Why is membership important? And why do I believe all RNs in Ontario should be members of their professional organization?

I think the answer lies in the key elements of membership.

The first element is participation. RNAO allows every registered nurse in Ontario to participate in optimizing their practice, addressing healthy workplace and best practice issues, and advocating for policies that protect health and promote the practice of nursing. When I ask colleagues why they chose nursing, the most common answer I receive is: "I wanted to make a difference."

Participating in RNAO as an active member allows you to make that difference. And the great part is you can participate in so many different ways. You can help to guide the work of a BPG, engage in political action by signing an *Action Alert*, or add your name to a petition that addresses the issues confronting your practice or community.

"I am issuing a challenge that we each bring at least one new member to RNAO by telling colleagues who are not members why we belong to our professional association."

The second element is belonging. That sense of belonging to your profession is part of every nurse's identity. Belonging to RNAO supports the image and impact of nurses. Membership allows the strength of a common purpose to flourish. And adding more voices ensures a sustainable health system that meets the needs of people, addresses the social determinants of health, and positions nurses as knowledge workers.

I have met nurses who have become acquainted with RNAO more than a decade into their careers. Many were disillusioned, felt they were no longer able to make a difference, and considered leaving the profession. These were strong, capable and competent RNs feeling adrift. Belonging to RNAO helped them to understand the reasons behind their malaise, and provided them with tools to access information and data to address issues they identified in need of fixing. Some of these same nurses became voting delegates at annual meetings. And I hope to see some run for positions on the board of directors in the future.

The third element is fellowship. While linked to belonging, fellowship is more about companionship and comradeship. For members of RNAO, there are countless ways to experience a sense of fellowship. The International Affairs and Best Practice Guidelines Centre offers numerous workshops, institutes and seminars for members. These provide opportunities for learning and building nursing networks. Chapter and regional meetings, and RNAO interest group meetings, are another way to share knowledge, create common goals, and foster a sense of nursing community. Active chapter or region members also get to attend assembly meetings. These gatherings generate that sense of fellowship, belonging and partnership, allowing members to share experiences with colleagues across the province.

I am a proud member of RNAO. Being a member, staying a member and encouraging others to become members only enhances our profession and the impact nurses have on health promotion, illness prevention and healthy public policy. This is where the fourth concept of enrollment comes in. RNAO has a proud history of being an effective organization. We have accomplished much, and we have much more to do. There is no question that if we encourage every RN in Ontario to become a member, we would add even more clout to an already strong association. That's why I am issuing a challenge that we each bring at least one new member to RNAO by telling colleagues who are not members why we belong to our professional association. We're already a powerhouse, and by growing, we will bring even more positive change for nursing and our patients. **RN**

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

Registered nurses shape whole-system change

PART 3 OF 3

This is the third and final installment in a series of columns that explore how nurses are leading and shaping change at the individual, organizational and system level. Sioux Lookout RN Paddy Dasno was featured in part one as a leader at the individual level. She placed a lawn chair where a park bench had been, vocalizing her concern that the homeless in her community are being further marginalized. Best Practice Spotlight Organizations (BPSO) Toronto Public Health, Fairview Mennonite Home and St. Elizabeth Health Care were featured in part two for shaping clinical practice and healthy workplaces by implementing BPGs.

I want to now bring this notion of leadership and influence full circle with examples of how RNs – collectively – are leading whole-system change. Where have we as a profession made an impact in the past, and where are we headed?

There are several past achievements that come immediately to mind when I consider this question. Thanks to nurses' expert advocacy, the provincial government passed legislation making a baccalaureate degree mandatory for practice in Ontario (2005). Influencing the government to make important changes to expand the nurse practitioner role (2010) and to open 26 NP-led clinics (the first in Sudbury in 2007) are victories we can also celebrate together. And, the push to see 70 per cent of Ontario nurses working full time began with RNAO in 1998, and continues today as we are closer than ever to our target.

Primary care reform, and the adoption of RNAO's 20 recommendations outlined in *Primary Solutions for Primary Care*, is our profession's next great challenge. RNAO launched the provincial task force behind this influential report in February 2012, and released its recommendations at the end of June. We've set ambitious timelines to maximize and expand the role of Ontario's primary care nurses – 2,900 RNs and 1,400 RPNs – and to eliminate the care gaps that prevent patients from accessing timely and co-ordinated care. The report offers a two-phase solution. Phase one deals with upward harmonization of the RN/RPN roles within the existing scope of practice. Phase two entails role expansion, including RN prescribing.

> "PRIMARY CARE REFORM, AND THE ADOPTION OF RNAO'S 20 RECOMMENDATIONS OUTLINED IN *PRIMARY SOLUTIONS FOR PRIMARY CARE*, IS OUR PROFESSION'S NEXT GREAT CHALLENGE."

RNAO is now developing an additional pillar for strengthening Ontario's health system. *Enhancing Community Care for Ontarians (ECCO)* proposes an evidence-based re-organization of community care. The expertise of RN case managers and care co-ordinators is central to making this happen.

ECCO proposes that interprofessional primary care models, such as community health centres, nurse practitioner-led clinics, aboriginal health access centres, and family health teams, expand their reach and role over the next three years with the support of a temporary *Primary Care Transitional Secretariat* placed within LHINs to organize local primary care clusters.

By 2015, interprofessional primary care organizations would provide complete care co-ordination and health system navigation, including the ordering of home care and support services. This would eliminate the need for community care access centres (CCAC). The 3,000 RN case managers and care co-ordinators currently working within CCACs would transfer to the primary care setting – with no loss of compensation – to offer their high level of expertise and system knowledge to the 10 per cent of Ontarians with the most complex care needs. The remaining population will receive care co-ordination and system navigation from the RNs who are currently employed in primary care. This approach will strengthen the role of RNs to best serve Ontarians from 'womb to tomb,' and allow same-day access to nurse practitioners or family physicians.

Stay tuned for more on this. Very soon you will see board members and staff on the road, seeking your feedback on these and other aspects of a renewed vision for nursing in Ontario. This vision will recalibrate the health system to place a much greater focus on wellness, health promotion, chronic disease prevention and management. Our work on this will ramp up, and we will be looking to you for help. Each act of advocacy builds on our momentum as a profession, and leads to important whole-system change that positively impacts on the profession and the public.

Through this series of columns, I've offered some inspirational examples of advocacy in action. Remember them. And look to them for inspiration when you embrace opportunities in your own communities, workplaces, and through RNAO. Help to create a system in which nursing practice has been maximized and expanded. An amazing profession made even more amazing thanks to the influence of each nurse as an individual, and all of us as a collective. **RN**

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

MAILBAG

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

Restraints as an effective care strategy

Re: The case against restraints, July/Aug 2012

We applaud the *Journal* for highlighting this issue, however the image used suggests nurses "resort to" becoming jail guards and treating clients as criminals, all in the name of safety. As mental health and addiction nurses, we were deeply offended by this image. It is a humiliating misrepresentation of the work done in managing a complex practice area. This imagery was inappropriate and an inaccurate reflection of how we promote safety. Nurses work hard to minimize restraint use. When needed, restraints are an effective care strategy that should be seen as non-punitive and used in a way that respects client dignity. Would it not have been better to use an image that portrays the "alternatives" rather than promote a myth that mistakenly connotes safety as trumping dignity?

Rani Srivastava
Toronto's Centre for Addiction and Mental Health

A reminder to stop and think

Re: The case against restraints, July/Aug 2012

I want to commend the use of imagery on your recent cover. I practise as a geriatric nurse in a very busy emergency department with wonderfully skilled colleagues who manage to juggle multiple acutely unwell patients, bring comfort to families and monitor at-risk elderly patients who may be demented or delirious. In this environment, it is difficult to have time to consider alternatives to the use of restraints for our frail elderly population. But your article asks us to stop and consider just one more time; is there an alternative? The picture you used of the elderly gentleman wearing handcuffs – I'm not sure I can put into words what this image tells us. I immediately tore this article out of the magazine and posted it in our staff lunchroom with a list of alternatives to restraints for all of us to review. Thank you for the conversation, the reminder that we can try again, and who we are trying for.

Sally Bonaldo
Peterborough, Ontario

> "THE PICTURE YOU USED OF THE ELDERLY GENTLEMAN WEARING HANDCUFFS – I'M NOT SURE I CAN PUT INTO WORDS WHAT THIS IMAGE TELLS US."

Welcome review of the impact of restraints

Re: The case against restraints, July/Aug 2012

As a director of nursing in a long-term care home, I take exception to the comment that restraints "are commonly used in long-term care homes." Restraint use is not "common." Long-term care homes in Ontario are regulated to demonstrate alternatives to restraint use. Currently, we have four residents restrained with a seatbelt in our 105-bed home. All are because of family wishes. It is my experience that when a resident has come from the hospital and a restraint was used there, the family trusts that assessment over the long-term care home's information. It is a constant trial-and-error, review-and-education process. Restraints do not belong on anyone.

Jan Shkilnyk
Dorchester, Ontario

Restraints: a necessary part of nursing

Re: The case against restraints, July/Aug 2012

I work on a fast-paced, acute floor with four patients during the day and sometimes seven at night. After patient assessments, assistance with activities of daily living, transferring patients onto and off stretchers for tests and procedures, medication administration, family and patient teaching, assisting with ambulation, collaborating with the allied health team and physicians, and much more, I am left with very little time to ensure patients who are confused and at a high fall risk do not hurt themselves or others. Often, I attempt to contact family to ask if they can come in to be with their loved one when I am caring for others. Even if it is a few hours, it may mean a few less hours that I have to use restraints. As nurses, we know that no matter what we do, restraints are sometimes a must to ensure patient safety. This article reminds us of the risks of improper restraint use. It helps us realize restraints are part of a bigger picture, and when organizations train staff and develop protocols to decrease risk, the benefits can outweigh the risks when using restraints.

Nour Al Farawi
London, Ontario

Publisher's note

A lot of consideration goes into the artwork for a cover. The editorial team felt it needed to make a powerful and symbolic statement about the use of restraints on patients and residents. The central message of the article and cover imagery is to challenge nurses to rethink their philosophy on restraint use.

NURSING IN TH

Ahead of the curve

Renovating and upgrading the endoscopy unit at The Credit Valley Hospital and Trillium Health Centre is a matter of great importance to **Vicky Sharma** and **Kiran Dhillon**. That is why the two RNs, who are members of Trillium's *Diwali 2012* fundraising committee, organized and hosted an August fundraising event dubbed *Giving 110 per cent On the Curve*. "We set it up as a networking night for young professionals," Sharma says. The pair's efforts paid off. They were able to raise over $4,000 in donations and $24,000 in raffle prizes, products and services. The fundraising committee's goal was $2 million. This and several other initiatives have raised $1.2 million towards a new endoscopy suite. The existing unit is 50 years old, cramped, and needs to be renovated to increase capacity, accelerate treatment and reduce wait times. The renovated suite will include a pre-procedure area, a waiting area that provides privacy, and new equipment. (*Mississauga News*, Aug. 17)

RNs Vicky Sharma (front, right) and Kiran Dhillon (front, second from left) raised $4,000 in August for a new endoscopy unit in Mississauga.

NPs Jennifer Tiberio (left) and Clea Lang (second from left) celebrate the opening of the Colorectal Cancer Survivorship Program with Health Minister Deb Matthews and MPP Michael Coteau.

Caring for survivors

You've beaten cancer. You're a survivor. Now what do you do? A unique, NP-led primary care clinic for colorectal cancer survivors in north Toronto now offers follow-up care for five years after patients are given the all-clear. NP **Clea Lang** is one of two nurses who are driving the clinic's Colorectal Cancer Survivorship Program. "The NP role is not just the physical part of monitoring cancer, it's also about assessing their emotional and functional needs," says Lang. As part of post-cancer care, Lang and her colleagues interpret blood tests, CAT scans, and conduct physical assessments, all the while screening patients for anxiety and depression. Funded by Cancer Care Ontario, the clinic has been operating out of the North York Family Health Team offices since the spring. It is unique because it combines nursing care with community based survivorship care. (*CanadianHealthcareNetwork.ca*, Aug. 13)

Embracing telemedicine

Helen Brenner, chief nursing executive and vice-president of patient services at Northumberland Hills Hospital (NHH), says she's "grateful" for new funding dedicated to telemedicine nursing support at the hospital. "Local patients can access healthcare services that they may not

E NEWS

BY CLAIRE O'KEEFFE

have previously been able to connect with here at home, including consultations with specialists," she says. The Ontario Telemedicine Network uses two-way computer videoconferencing to give patients access to care. The videoconferencing also permits educational programs and meetings for health-care professionals. "Telemedicine is also adding to our ability to enhance training and development opportunities for our staff, giving us an inexpensive and timely way to tap our health-care team into the expertise of professionals at other centres." Across the Central East LHIN, where NHH is situated, 20 telemedicine nurses have been recruited, and the service is available at more than 80 sites. (*Northumberland Today*, July 23)

Nurse sues police after G20 arrest

Alicia Ridge volunteers as a nurse at a sexual assault centre. She is studying to also become a midwife. But her political rather than academic pursuits are what made news in August. Ridge is one of seven residents from the Hamilton area who are suing Toronto police for alleged false arrest, battery and malicious prosecution during the G20 summit in 2010. The five women and two men who have launched a $1.4 million lawsuit say police officers targeted them for arrest using "unreasonable criteria" and made "profane, sexist and homophobic" comments. "The police officer encouraged the crowds to call us names and take pictures," Ridge said at a press conference on Aug. 1. "Despite the presence of female officers, I was searched by a male officer and it was a fairly pathetic rendition of a search...a quick hand up a leg followed by a swift ass grab, and there were lots of sexualized comments that went along with it." Investigators substantiated Ridge's claim that her arresting officer called her a "dyke," made obscene insults, and told her to shave her legs. (*thestar.com*, Aug. 1)

Report finds poor are less healthy

Regent Park Community Health RN **Laura Hanson**, a former policy analyst for RNAO, spoke to CTV news about a recent Canadian Medical Association survey that found Canadians who have lower incomes report inferior health to those who are wealthier. The survey, conducted by Ipsos Reid, suggests good health goes hand-in-hand with wealth. "Many people just live day-by-day," Hanson said when asked why income plays a role. "They have multiple jobs... they're struggling." The survey also concluded that Canadians with lower incomes use health services more often than their wealthier counterparts. As well, 25 per cent of Canadians earning less than $30,000 annually have delayed or stopped taking prescription drugs because they can't afford to pay for the treatment. (*CTV News, The Globe and Mail*, Aug. 13)

OUT AND ABOUT

WINDSOR STUDENTS SHOW THEIR PRIDE

Three nursing students from Windsor's St. Clair College show their support for the lesbian, gay, bisexual and transgender community by walking in the city's Pride parade Aug. 12. (L to R) Fourth-year nursing students Alaina Delaney and Charlene McInnis, and second-year student Amanda Levesque proudly carried an RNAO Essex chapter banner in the procession.

ALGOMA RNs HOST JOHNSTON VISIT

(Left) Sharon Johnston, wife of Governor General David Johnston, visits Algoma Family Services (AFS) in Sault Ste. Marie on Aug. 30, where staff provided an overview of the facility, its successes, and its programs. She is pictured here with AFS Executive Director and RN Pierrette Brown.

NURSING IN THE NEWS

Men of merit

Kawartha Sexual Assault Centre RN **Mary Waters** hopes a provocative poster campaign that was launched in August will generate dialogue around the subject of sexual abuse. One in two girls and one in five boys will be sexually assaulted at some point in their lives. The campaign, which focuses on alcohol-facilitated sexual assaults, is called *Don't Be That Guy*. Posters aimed at males, with taglines such as 'Just because you help her home doesn't mean you can help yourself,' have been placed throughout Peterborough's Fleming College and Trent University. Waters says "this is our opportunity to get (this issue) out there." She adds that often, in court, a complainant's dress, her level of intoxication, even if she was flirting or not, comes into question. This takes the blame from the perpetrator and places it with the victim, she suggests. The result is an impression that it wasn't really rape. Waters says the campaign is also attempting to encourage men to stand up to their friends if they believe they're about to cross the line. (*The Peterborough Examiner*, Aug. 30)

PHOTO: QMI AGENCY

RN Mary Waters (left), with colleagues Karen Basciano and Karen Giles, hopes to get men talking about strategies to stop alcohol-facilitated sexual assaults.

OUT AND ABOUT (CONTINUED)

CONTINUING THE CALL FOR 2014 *HEALTH ACCORD*

At a July 18 gathering meant to bring attention to threats against Canada's health-care system, RNAO CEO Doris Grinspun (right) joins (L to R) Roy Brady, Council of Canadians/ Ontario Health Coalition, Sean Meagher, Canadian Doctors for Medicare, and Ritika Goel, Students for Medicare, to call on Prime Minister Stephen Harper to engage in talks about a 2014 *Health Accord*. The event, in Toronto's Riverdale Park, also marked the 50th anniversary of Medicare (see related letter, right).

LETTER TO THE EDITOR

Following a Canadian Medical Association survey that found health can be linked to wealth, RNAO urged Prime Minister Stephen Harper to get back to the negotiating table for talks on the 2014 Health Accord. *In response to a* Globe and Mail *article in which the federal health minister reiterated the government's reluctance to sign a new* Accord *(Aug. 14), RNAO CEO* **Doris Grinspun** *wrote:*

Nurses want serious dialogue

The federal government's failure to grasp the important role it plays in the delivery of health care in Canada is mind-boggling. We agree wholeheartedly with the Canadian Medical Association (CMA) that equity and fairness are central tenets of our health-care system. Nurses and physicians also know there are gaps in services between rural and urban areas across this country. The results of a survey released this week by the CMA offers further proof that aboriginal communities and people living in poverty aren't getting the attention they deserve when it comes to their care needs. Nurses call for Prime Minister Stephen Harper and Health Minister Leona Aglukkaq to come to the table and engage premiers, territorial leaders and the public in a serious dialogue about a new *Health Accord* so we can chart the right direction for our system.

Doris Grinspun, CEO
RNAO

NURSING NOTES

Diabetes education on the web supports self care

London's St. Joseph's Health Care has a new Diabetes Education Centre (DEC) website. Its home page has six pastel-coloured squares. Click on the orange square for patient resources. Click on the dark purple square for tips on living with Type 2 diabetes. It's a modern, efficient way to ensure swift and simple access to information on the disease, says DEC NP Maureen Loft, noting it is meant to be helpful for patients, health providers and the public. "With proper education and follow-up support, diabetes can be self-managed very well, and the devastating complications of diabetes – such as blindness, kidney and nerve damage – can be avoided or minimized," she says. Plans have already been made to add interactive educational tools to the site, Loft adds, including videos and possibly a forum where people can share experiences. "We absolutely want to harness the power of the Internet…to help our patients help themselves."

The DEC team at St. Joseph's Health Care in London is proud of its new website (www.sjhc.london.on.ca/diabeteseducation). (L to R) Mary Biro, Lisa Jorgensen, Valerie Lammers and Maureen Loft.

PHOTO: MARK HAMON, ST. JOSEPH'S HEALTH CARE LONDON

Student loan forgiveness for nurses

Beginning next spring, nurses and NPs who work in communities of 50,000 people or less across the country may qualify to have part of their student loan waived. Simcoe-Grey MP Kellie Leitch, a physician who is also Parliamentary Secretary to the Minister of Human Resources and Skills Development and to the Minister of Labour, said in August: this initiative "will not only alleviate the high cost of education and training for many Canadians in this field, but will also encourage more health-care professionals to work in the communities that need them most." Nurses and nurse practitioners who started working in selected communities on or after April 1, 2012 can receive up to $4,000 per year (and a maximum of $20,000 over five years) in Canada Student Loan forgiveness. To find out more, visit www.hrsdc.gc.ca.

Ottawa RN continues clean water crusade

Bea Osome continues her crusade to ensure more villages in western Kenya are provided with fresh, clean water. Thanks to her efforts to date, residents in her native country are able to access water from six hand-dug wells. The Ottawa-based long-term care nurse would like to complete four more. Osome arrived in Canada from Kenya in 1971. Since then, she has worked to provide the residents of her home village of Kiritu, and her husband's home village of Mumboha, with clean water. She says it typically costs her $4,000 to build a well. Osome's last trip to Kenya was from January to March 2012. During that visit, she oversaw the construction of one well. She says she will be raising funds for the remaining four wells, and welcomes RNs to join her on any future trips. To contact Osome, or for information on how to donate, email beaosome@yahoo.com

Remembering Sonia Varaschin

Planning for a fundraiser in memory of Sonia Varaschin has begun, on the heels of the second anniversary of the Orangeville nurse's tragic death. Varaschin's body was found in Caledon in September 2010. Her killer has not been apprehended. The Registered Nurses' Foundation of Ontario (RNFOO) will host an event on Feb. 23 at St. Michael's College School in Toronto. The second annual fundraiser will feature Zumba fitness classes and dance shows. All proceeds will go to an RNFOO scholarship – in Varaschin's name – that supports nurses focusing on healthy work environments. The goal of the event, explains Varaschin's friend and former colleague, Marija Bojic, is to "keep the memory of Sonia alive, and support a culture of wellness, giving and remembrance among nurses."

In memoriam

RNAO EXTENDS ITS DEEPEST CONDOLENCES TO FAMILY AND FRIENDS OF:

Diana Dick, a nursing leader who held many roles throughout her career. The former RNAO co-ordinator for professional issues (1983 to 1988), and champion of the *Canada Health Act*, passed away July 11.

Ogugua (Charles) Ikocha, a Region 6 RNAO assembly representative and RN at the Centre for Addiction and Mental Health, tragically passed away in a drowning accident July 30.

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

New country, no care

Nurses express outrage at the federal government's decision to roll back health-care services for refugees.

BY MELISSA DI COSTANZO

RN Hodan Ali is director of Hamilton's Centre for Newcomer Health.

Samantha* received regular prenatal care from an obstetrician throughout her pregnancy. With less than 10 weeks to go before her due date, the refugee claimant from Hungary was abruptly turned away from an appointment with her specialist. Shocked and confused, and suddenly without access to a health-care provider to monitor her baby's progress, Samantha turned to Hamilton's Centre for Newcomer Health. Whether it was confusion on the health-care provider's part, or a legitimate denial of access, Samantha's health was impacted: she was 35 weeks pregnant and hypertensive, thanks to almost three weeks without care.

Hodan Ali, a registered nurse and director of the clinic, helped to restore the young mother's health. Had her condition been monitored, this risky situation for mom and baby could have been avoided, she says. This is not the first time in recent memory that Ali has heard of a refugee's difficulty accessing health care. And with the cuts to the Interim Federal Health Program (IFHP) that went into effect on July 1, 2012, it won't be the last.

> "The Canada I am honoured to be a part of has **no place** denying care to needy people. They have already lost every human comfort. Please do not take away their **health**."
> **TAUCHA INRIG**, RN, MARKHAM, ONTARIO

Earlier this year, Jason Kenney, federal Minister of Citizenship, Immigration and Multiculturalism, announced changes to IFHP that severely curtail the health coverage that many refugees rely on. The IFHP provides temporary, basic health-care coverage – often in addition to supplementary services such as dentistry, vision and pharmaceutical – to refugee applicants. Those who are successful with their claims will then qualify for provincial or territorial health coverage, depending on where they live.

Claimants who have applied for protection as a refugee are no longer able to access supplemental health benefits for prescription drugs, dental and vision care, or medical devices (such as wheelchairs). Rejected refugee claimants (as well as refugees from a designated "safe" country list, which has yet to be released by the government) will only be covered for conditions that are considered a public health risk, such as tuberculosis.

The decision to roll back health-care coverage for many of these people marginalizes a population that is already vulnerable, says Ali, noting many of these individuals have left their home countries to escape war, persecution, violence, or political upheaval. Some come to Canada with numerous health-care issues such as post traumatic stress disorder, gunshot wounds, malnourishment, infections, diabetes and high blood pressure. Above all, mental health is the most prevalent concern since refugees are at higher risk for mental health issues within the first year of their relocation, Ali says. Many of her clients have witnessed and experienced traumatic situations, such as living in run-down refugee camps. Migration stress only adds to the woes.

The cuts also create a barrier for new refugees who have just arrived to the country. These individuals likely face monetary issues, language roadblocks, and culture shock, says Ali. Now, they must also make difficult choices as a result of having to pay out-of-pocket for medications or trips to a provider. Some families will face the agonizing decision between rent and food, for example, and health care, she adds. Others won't even attempt to access health care or medications due to the cost. Ali predicts this will land them in an emergency room down the road with severe symptoms.

"Whether it's diabetes, epileptic or psychiatric medications, for example – these are essential medications that people can't go without," she says. "As a front-line worker, I just cannot wrap my head around (the policy change). It doesn't make an ounce of sense."

The federal government's cuts to the IFHP hit particularly close to home for Ali, a former refugee claimant who fled Somalia with her family in 1989 when she was just 11 years old. "If my family had come today, we'd be in the same boat," she says. "It's the responsibility of our government to ensure that people have access. This (change) goes against everything we value in terms of health care and general policies."

Many of Ontario's health-care providers immediately condemned the changes, calling them inhumane and unfair. Organizations across the country called on the government to rescind the cuts. RNAO added its voice to the chorus, criticizing the changes and issuing an *Action Alert* that urged nurses to speak out.

Almost 950 nurses, nursing students, other health-care practitioners and members of the public from across the province – and the nation – answered the call, the vast majority echoing RNAO's concern that short-term savings for the federal ledger-book will cost more in the long-term, as complications from medical conditions and emergency care are more expensive than prevention and early intervention through primary care. "Some asylum-seekers and protected persons will die from this new federal barrier to health care," reads the association's *Action Alert*. "Children will no longer be able to get their asthma medicine. People with diabetes will have trouble accessing their insulin, as will others needing life-saving medication."

In May, RNAO President Rhonda Seidman-Carlson and CEO Doris Grinspun wrote an open letter to Prime Minister Stephen Harper and Ontario Premier Dalton McGuinty, saying Ontario's nurses are "gravely concerned that these dangerous changes will

** Pseudonyms have been used to protect privacy.*

> "We urge you to reconsider…to protect our standing as a country that the **world respects** for its comprehensive public health care."
>
> **VIVIEN RUNNELS**, MEMBER OF THE PUBLIC
> OTTAWA, ONTARIO

threaten the lives and well-being of people who have already experienced trauma and hardship before they arrived in Canada." It went on to say Ontario's nurses "implore all federal and provincial leaders, from every party, to work together to correct this inhumane, egregious, and short-sighted policy decision." Grinspun also spoke at a rally in Vancouver while attending the Canadian Nurses Association (CNA) convention, where a motion was unanimously passed urging the federal government to reconsider the change.

Ontario's Health Minister Deb Matthews wrote a letter to Kenney and her federal counterpart Leona Aglukkaq, saying this policy change will create "a class system for health care in Canada." She added: "even in emergency circumstances, your changes will see certain refugee claimants receiving no health-care coverage at all. Should a refugee claimant suffer a heart attack, your government will now refuse any health-care coverage. It is grossly irresponsible to withhold funding for this care in such a life-threatening situation."

The outcry from the health-care community seemed to pay off. Late in June, just days before the changes came into effect, Ottawa clarified its stance, saying government-assisted refugees (those referred by the United Nations and supported by the federal government) would be exempt from the cuts.

Although a welcome concession, health-care practitioners worry about those refugees still denied access under the new program.

When Sue Grafe learned of the changes, she was incredulous, and quickly signed RNAO's *Action Alert*. "I don't think it's right to play games with people's health," says the nurse practitioner who spent six years working at Hamilton's Shelter Health Network. Many of the people she helped were refugee claimants and government-assisted refugees, who often head to a shelter after they first arrive in Canada. Grafe now works part-time with Ali at Hamilton's Centre for Newcomer Health.

The federal government argues the changes are necessary to deter abuse of Canada's refugee determination system, explains Julie Lafortune, communications advisor with Citizenship and Immigration Canada. In an email to RNAO, she writes: "As the minister has noted, 'with this reform (to the IFHP), we are taking away an incentive from people who may be considering filing an unfounded refugee claim in Canada.'"

But targeting health care, Grafe charges, is the wrong route. "If you want to deal with the perceived issues in an administrative way, go ahead. But not health care. Health care should be off the table."

Kenney says the change will save $100 million over the next five years, a statement that has Grafe shaking her head. Some refugees affected by the cuts will have no choice but to visit their local emergency room to receive care – a cost that the provinces and territories will have to absorb. This, in turn, will continue to put pressure on staff already dealing with high levels of patient admissions and acuity, she argues.

Grafe also warns the burden of the cuts won't be limited to health care. She thinks other social service agencies – such as food banks – will also feel the impact. "Primary care saves money. Preventive care saves money. We know this as nurses," she says.

Like many of her counterparts, Grafe will continue to facilitate care for those affected by the cuts as best she can. The Centre for Newcomer Health does not charge for visits, which means clients will still be seen. But if someone comes to her in semi-urgent condition, Grafe may not be able to order a chest x-ray or blood work, for example. This means she will have no choice but to send them to the ER – a decision that weighs heavily on her mind because she knows the impact that will have on the individual and the system.

It's also a tough safety choice she'll be forced to make: Grafe's hands will be tied because she won't be able to provide immediate care. As a Canadian health-care practitioner who describes herself as a champion of universal health care, Grafe says these decisions break her heart. "How can you say 'this person is worthy of health care' and 'this person is not worthy of health care?'" she asks. "It's stigmatizing, and it's not Canadian to me."

Grafe continues to advocate on behalf of her clients. She participated in the June 18 *National Day of Action* protest in Hamilton, one of many demonstrations that took place in cities across the country, including Toronto, Ottawa, Kitchener, Windsor, Winnipeg, Vancouver and Montreal. The event was supported by RNAO and other organizations, including CNA and the Canadian Association of Midwives.

> "Being born in Canada is like winning the **lottery of life**. Refugees come here in the hope of **improving** their lifestyle, which includes healthy outcomes."
>
> **MARGIE WARREN**, FORMER RN
> WATERLOO, ONTARIO

> “Risking the lives of people who have already experienced **trauma** and hardship prior to arriving in Canada is inhumane and completely **unacceptable**.”
>
> **HEATHER LOKKO**, RN
> LONDON, ONTARIO

Vanessa Wright was on hand for the Toronto rally, and has also been advocating strongly on behalf of this issue. The Toronto-based nurse practitioner works at Crossroads Refugee Health Clinic at Women’s College Hospital. The changes motivated her to appear in a two-minute YouTube clip called *Not the Canada That I Know*, a project initiated by Canadian Doctors for Refugee Care.

In the video, Wright shares stories about recent refugee patients, and disputes the government’s claim the cuts will reduce costs, promote public health, and promote fairness. “What does this mean for people (who) have escaped war, starvation, torture and other forms of persecution, and seek Canada as a land of hope and opportunity?” she asks. “This is not the Canada that I know.”

Wright has also talked to staff at community health centres and hospitals across the city about the implications of the policy change, including the expected influx of patients who will head to the ER with urgent symptoms. She’s communicated with representatives from universities in Ottawa, Toronto, Hamilton and Montreal, providing students with copies of a letter that contains details about the cuts. She’s encouraged students to mail the letters to chief nursing officers, urging them to pass the information on to front-line workers.

Nurses, she says, are strong in numbers. In Ontario alone, there are roughly 140,000 RNs, NPs and RPNs. Wright wants to create a coalition to collectively decry the cuts. “Often, nurses are the first providers patients see, and nurses can be real advocates,” she says. “We look at patients as a whole, which is why we see that having health insurance stripped (away) will highly impact all the different determinants of health refugees are facing when they first arrive.”

Wright is hopeful the policy will be reversed. “People won’t stop being angry about this. Health care is a human right,” she says. “That’s the way I practise.”

That’s also the way Roseanne Hickey sees things. A primary health-care nurse practitioner at the East Mississauga Community Health Centre, Hickey shares three examples of real-world refugee stories, including those of Mr. and Mrs. Finza,* CHC patients from Hungary who have complicated health problems. Their health is dependent on their IFHP coverage. The Finzas are both at high risk for cardiovascular disease, and require IFHP coverage for a number of medications that decrease their risk of heart attack and stroke. John* is also from Hungary. A respirologist has ordered tests to determine the root cause of his serious breathing problems – tests that are covered by IFHP. Katie* is a 14-year-old girl from Nigeria. She has sickle cell anemia. If left untreated, her illness could cause serious, life-threatening complications. Katie requires ongoing care from a specialist, which is no longer covered by the IFHP.

The list goes on, she says, and will only continue to swell.

> “This will have **greater** impact in the long term on the health and welfare of this population and ultimately **not** save health-care dollars.”
>
> **JUDY WALDMAN**, RN
> TORONTO, ONTARIO

“There is not much credence or consideration being given to these people,” she comments. “It goes against everything that physicians and nurses, and Canada, aspires to.”

Like Hickey, Wright and Grafe, Ali continues to advocate for her clients and their right to care. She says she will closely monitor the impact of the cuts, adding a cost analysis will be conducted at the Centre for Newcomer Health that will determine the financial impact if the IFHP had remained unchanged, and the price tag of using acute care staff to treat primary care needs. She has also provided hospitals with a tracking device that will monitor the increase of patients coming through the local ER doors.

Ali says the advocacy, and the outcry from practitioners across the nation, is important, but admits she is anticipating the worst. “I guarantee we will see people die because they haven’t received basic Medicare,” she predicts. “Eventually, someone will get hurt. And it will be sad to see that day.”

Despite this, she is not discouraged. “We shouldn’t be marginalizing an already marginalized population, and putting them on the sidelines. We’ll keep pushing, until the policy is reversed,” she promises. “This is not the end of it. It’s just the beginning.” **RN**

In this YouTube video opposing the cuts to IFHP, NP Vanessa Wright disputes the government’s claim the change will save money and promote fairness.

MELISSA DI COSTANZO IS STAFF WRITER AT RNAO

** Pseudonyms have been used to protect privacy.*

 BY CLAIRE O'KEEFFE

Advocating a healthy start in life

WINDSOR RN REPRESENTS NURSING ON PROVINCIAL PANEL TO ADDRESS CHILDHOOD OBESITY.

Carol Diemer understands the torment obese children suffer. Jack,* a 13-year-old boy who has struggled with his weight since the age of eight, and who is now dealing with depression and stress, has been a client for much of his youth. "It breaks my heart to see children who are struggling with (obesity) psychologically, socially, physically," the Windsor RN says. "I feel anger at the disparity and challenges that some (children) deal with...and sadness for the shame (Jack) has to endure due to his weight."

Diemer says Jack wants to lose weight, but his social circumstance is throwing a wrench in his plans. He and his younger brother live with their mother, a single parent whose annual income is less than $20,000. Limited resources make it impossible for many families to access healthy foods, she says.

This is not the first time Diemer has seen how a child's socio-economic status can impact on weight. Education and exposure to certain media and advertising can also lead to childhood obesity. Diemer and her team at Windsor Essex Community Health Centre (WECHC) are currently treating an estimated 20 children with obesity problems that may be linked back to these influential factors. This is why Ontario's Ministry of Health chose her to help recommend holistic solutions to the problem.

In May, the Windsor RN joined a 17-member *Healthy Kids Panel* as the RN representative. The panel includes professionals from health care, education, advertising, social marketing, academia, and more. She says the group will think holistically as it develops recommendations for the government strategy that hopes to reduce Ontario's childhood obesity rate by an ambitious 20 per cent in five years.

"The panel is here to look at the problem in a way that it hasn't been looked at before," she says.

If you asked a teenaged Diemer what her future career might be, she admits nursing wasn't in the picture. She always wanted to become a veterinarian, but changed her mind thanks to the promise of a guaranteed nursing job after graduating from the nursing program at St. Clair College in 1984. Diemer soon discovered the profession suited her sociable personality.

She began her nursing career at Windsor's Hotel-Dieu Grace Hospital (HDGH), starting out on the neurosurgical unit and moving to the ICU shortly after. By the mid-90s, she became a research co-ordinator with a focus on allergies, respirology and critical care. Two decades after graduating, her focus shifted once again – this time to mental health. By 2006, she was manager of the *Schizophrenia and Psychosis Project* at Windsor Regional Hospital, followed by unit manager of HDGH's mental health program. Diemer credits her experience in mental health for preparing her to shift gears once again to the community and her present position at WECHC as staff nurse. Mental health "improved my outlook as a nurse overall," she says.

During her initial three years at WECHC, Diemer led the development of local health initiatives, including a childhood obesity strategy. Key to that strategy was the organization's implementation of RNAO's *Primary Prevention of Childhood Obesity* best practice guideline in 2010. Her efforts ultimately led to the community health centre's Best Practice Spotlight Organization (BPSO) designation this past spring.

Diemer and her colleagues have their work cut out for them when you consider Statistics Canada reports childhood obesity rates have tripled in the last 20 years.

Whether in her day-to-day work or as a member of the provincial panel, Diemer says she's eager to help solve this issue. "Knowing that I can be part of a healthy change for (these children), knowing that I have made a difference, fulfills my journey as a nurse." **RN**

Three things you don't know about Carol Diemer:

1. Her four siblings are nurses.
2. She has a black belt in karate.
3. The person she most admires is her mother.

Claire O'Keeffe is editorial assistant at RNAO.

The expert panel's report to the Ministry of Health is expected by the end of 2012. For more information, visit www.RNAO.ca/healthy-kids-panel

** A pseudonym has been used to protect privacy.*

SPREA

VERONIQUE BOSCART

JAMES CHU

PAULA POP

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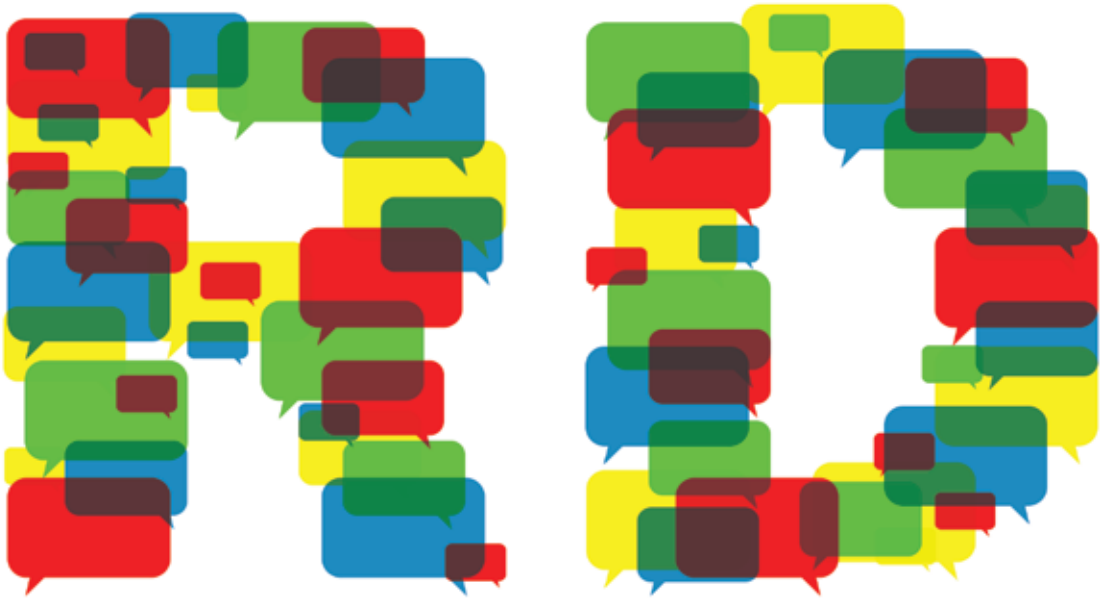

Veronique Boscart, James Chu and Paula Pop never expected to become ambassadors for RNAO. But after joining the association, they realized just how membership leads nurses down surprising, exciting and rewarding avenues. Whether involved in an interest group or on a chapter's executive, as a member of a best practice guideline panel, or a participant in advocacy efforts at the provincial or federal level, these RNs talk openly with peers about their experiences, and inspire others to fill out their membership forms. What motivated them to join their professional association, and how are they motivating others to do the same? **BY MELISSA DI COSTANZO**

VERONIQUE BOSCART

Veronique Boscart moved to Canada from her native Belgium in 2000. Once settled, she began working in acute care. She recalls an elderly man who had been admitted on her unit, but who "should not have been in the hospital to begin with." He had behavioural issues, was being restrained, and had also contracted MRSA and VRE. "I didn't fully understand the role of being an advocate as a nurse at that time," she admits. "But I knew that man should have been in long-term care."

As a new RNAO member, Boscart dialed up the association and asked for advocacy advice. To her delight, she received help and support "to start having a discussion with the physicians and the managers to say 'we are not doing a good job in improving quality care here.'"

RNAO helped to boost Boscart's confidence and gave her the courage to initiate that conversation with colleagues. And thanks, in part, to her advocacy, that elderly gentleman was eventually transferred to a long-term care home.

Boscart says she was floored by this experience and began delving deeper into RNAO's offerings. She became more familiar with both the profession and the association, and began to understand how nursing contributes to the broader health-care system. She learned how to speak out for patients, and how to influence population health.

"To be a leader and to be an advocate, you need to be well-informed and you need to be part of a larger group that's going to create that community where you can stand up and advocate for what is important," she says. "RNAO has really done that for me."

Boscart began to discover a passion for health policy and political issues, and developed relationships with key stakeholders in her community, including MPP and Conservative Health Critic Christine Elliott. She says RNAO's high profile at Queen's Park, and advocacy for nursing and health-care issues in the political arena opened up this opportunity.

In 2002, Boscart joined RNAO's Nursing Research Interest Group (NRIG), assuming the roles of secretary, vice-chair and then chair over the span of eight years (from 2002 to 2010). These positions gave her a fresh perspective on the importance of supporting students to grow professionally. Interest groups help open students' eyes to advocacy, she says, which is a crucial part of the job. "I feel it is my duty to make sure (students) understand that."

Boscart has moved from acute care to research, and holds the CIHR Schlegel research chair for enhanced seniors care through funding from the Research Institute for Aging, Conestoga College and the University of Waterloo. She's also become an RNAO workplace liaison at Conestoga College, and is one of over 300 Ontario RNs who act as representatives of the association. In fact, Boscart has been rewarded for her impressive recruitment track record, receiving free membership for a full year three times thanks to the number of nursing colleagues she's brought on board.

Boscart says RNAO helped her build up her Canadian nursing knowledge. Now, she's paying it forward to as many peers and students as possible. "I truly think RNAO has so much to offer – it's a shame if you're not a member," she says. "There's so much that nurses can do together."

If your phone number has changed, or you're moving, don't forget to let RNAO know.

Did you know members can submit resolutions that influence the direction of RNAO?

Members can take advantage of preferred rates for conferences, workshops and institutes.

Did you know you can receive a digital copy of *Registered Nurse Journal*?

JAMES CHU

Twelve years ago, as a nursing student at Humber College, James Chu began to learn about RNAO from fellow students and faculty members. He read about networking opportunities, students' access to conferences, and the association's chapters and regions. His interest was engaged, and he decided to fill out a membership form.

He realizes now just how little he knew about RNAO. "It's much more than (workshops and programs like LAP)," he says.

In 2005, the president's seat of RNAO's Nursing Students of Ontario (NSO) interest group opened up, and Chu ran for the position. Besides looking good on his resume, he knew it would offer the networking opportunities he craved.

He went on to lead the group for two years, which opened the door to numerous prospects. "Being part of a bigger group than just your local nursing students, being able to be a part of a bigger message, being part of something that's fulfilling, not just in the present, but in the future" were all rewarding aspects of sitting at the helm of NSO, Chu says. "It just opened my eyes... nursing is not just the clinical aspect. It's much more than that."

As a result of his involvement, Chu attended conferences and met with executives such as RNAO CEO Doris Grinspun, and honed his leadership skills. "I never imagined for a moment that I would build some of the relationships that I have," he says, adding that "those relationships have helped me to develop my personal character as well as my leadership."

Chu, who now works in the emergency department at the Children's Hospital of Eastern Ontario, is eager to recommend friends and colleagues join the association. He says he's proud to have played a role in the recruitment

of nurses, a handful of whom have gone on to lead active roles with their local chapters. "That's the most rewarding factor: seeing people become more and more heavily involved," he says. "That makes it important to me, because I'm seeing they're getting the most out of their membership."

After graduating, Chu took up the secretary position with RNAO's Region 10 (Ottawa) for two years. He's scaled back his involvement due to his heavy workload, but is hoping to ramp up his participation again. "I think you can get much more out of the membership being more directly involved," he says, admitting "I wouldn't even have had half of the experiences that I did as a student, and even early on in my career" if not for RNAO, he says, promising to continue to convey this message to colleagues who may be on the fence about joining.

Given his experience, Chu knows there are still lots of options to explore when it comes to his ongoing involvement with RNAO. After all: "You never know who you're going to run into, and you never know what avenue your membership will take you down."

If you're a member, why not get involved in one of 31 RNAO interest groups?

Chapters and regions are your connection to RNAO. To find yours, email info@RNAO.ca

A lawsuit can turn your world upside down. Join LAP now and enjoy peace of mind.

Membership satisfies your professional liability protection requirement.

PAULA POP

Paula Pop was studying RNAO's *Risk Assessment and Prevention of Pressure Ulcers* best practice guideline (BPG) during her first year of nursing at York University when she became intrigued by the association, and what it has to offer. She started to explore RNAO's website and within a matter of weeks, she had signed up to become a member. "It started with the guideline, but then I realized there was a plethora of information available...and so many different nursing-related avenues that RNAO offered," she explains. Plus, student membership was reasonably priced ($20/year) for what she could access (career counseling services and resources, educational opportunities and more).

Initially, Pop was specifically interested in the BPGs. In her second year of studies, she began volunteering on a panel for RNAO's *Safe Sleep Practices for Infants* BPG (the guideline is still in development). It's a rigorous process, admits Pop, but she enjoys working with peers from different professions who have the same goal in mind: collecting and presenting the best evidence that supports clinical practice.

Before long, Pop's interests widened as she learned more and more about the importance of health advocacy through her schooling and the association. "As nurses, we're taught from the first year of college that we're patient advocates." RNAO's emphasis on strengthening healthy public policy motivated her to encourage fellow students to join. By her fourth year at York, Pop had become the RNAO representative on campus, promoting the offerings of the association and recruiting colleagues. Her experience on the BPG panel intrigued fellow students, many of whom asked how she became involved.

By promoting RNAO, Pop was able to bring students together to discuss common interests. They even joined forces to share opinions during the last provincial election. About 40 students joined RNAO thanks to Pop's efforts. "I hope they (experience) what I've experienced," she says. "I've gotten a lot out of RNAO."

Pop graduated earlier this year, and is now working at Rouge Valley Health System as a staff nurse. Once the safe sleep BPG is completed, she sees herself becoming involved in another panel, or an interest group (or two). Signing on to become a workplace liaison is also an idea she's toying with.

Pop admits she has only touched the tip of the iceberg. "(Recruiting people) is how I can give back, not only to RNAO, but to my (nursing) community." **RN**

MELISSA DI COSTANZO IS STAFF WRITER AT RNAO

RECRUIT...AND REAP THE REWARDS

RNAO values the role of recruiters, and offers a number of incentives to members who get friends, family and co-workers to join. The "Get 7" program is just one example. If you recruit seven new RNs, your next year's membership is on us.

For every RN you sign up as a new member, you can also earn a $20 RNAO gift certificate that can be used towards future membership fees or RNAO conferences and workshops. For every undergraduate student you recruit, you will earn $5. Remember to have new members include your name and your membership number on their applications.

If every member gets one RN to sign up, RNAO's numbers will double. That means over 65,000 nurses and nursing students will be speaking out for nursing, speaking out for health, and influencing healthy public policy to advance the profession and improve health outcomes for Ontarians.

RNAO on campus

Students and faculty team up to promote the benefits of RNAO membership, and the value of active involvement.

BY KIMBERLEY KEARSEY

Katherine Gilbert studied for three years in the faculty of science before moving to the collaborative nursing program at Durham College/University of Ontario Institute of Technology (DC/UOIT). The seasoned volunteer and self-professed "sponge" says she didn't hesitate signing up for RNAO student membership right from the start of classes in 2009. It's no wonder then that this go-getter left a mark on students and faculty when she graduated this past spring. In fact, her successors may not realize it, but they owe her a debt of gratitude for her efforts to incorporate the cost of RNAO student membership into the school's ancillary fees. Thanks to Gilbert, they now have access to a range of benefits reserved especially for Ontario's next generation of RNs.

Rewind three years to a chance meeting between Gilbert and Humber College student Poonam Sharma – who spearheaded a similar effort in her collaborative nursing program – and you'll understand the inspiration behind the initiative. Gilbert learned of Sharma's efforts and wanted to take on the project in Durham. "It was just an idea over dinner," she admits.

"I think belonging to your professional organization prior to beginning your career gives you a more rounded experience," she says. As for her personal motivation to take on the challenge of getting buy-in from administrators and students: "Becoming a nurse was more of an identity to me. I didn't want to just focus on the school aspect," she explains. "I wanted to go out and network and be involved."

Marianne Cochrane, co-director of the DC/UOIT nursing program at the time, and a board member for RNAO now, says she saw a spark in Gilbert right from the start. That's why she invited her to attend the association's 2010 annual general meeting. As a mature student, she had life experiences that helped her to understand the value of involvement, Cochrane says. She was thrilled when Gilbert got the initiative going at DC/UOIT. Students now pay $15 and start the year off with a membership package describing everything that's available to them through their professional association.

It may seem like a simple concept, but the work behind this kind of administrative shift is significant. For Gilbert, it involved visits to a number of classrooms, presentations about the benefits of membership, conversations in the hallway about the opportunities for involvement, and a student referendum.

"I've always had so much faculty support and that was basically what gave me the confidence to really push forward," she says. "Most of our faculty members are active RNAO members, so going into their classrooms and talking about RNAO was never an issue."

Cochrane's membership stretches back to the 70s. She has been a member of the board of directors three times, and says she championed the idea because it "doesn't make sense to me not to belong." Students are the future, she explains. "I need to know they'll be there continuing on the work when I'm slowing down. They need to be involved right at the beginning so they can understand the complexity (of nursing) and the opportunities to find their voice and speak out."

Cochrane says it takes most students until second year to realize what they're missing by not becoming active RNAO members. She wants to change that, and is harnessing the energy and ideas

Katherine Gilbert (left) and Marianne Cochrane joined forces in 2010 to bring the benefits of RNAO membership to all nursing students at DC/UOIT.

PHOTO: JEFF KIRK

of young people to make it happen: "The more I see in a student, the more I'm willing to give. If they start to soak things up like a sponge, I start to pour more in."

Gilbert, who is now a registered nurse at Newmarket's Southlake Regional Health Centre, says going into classrooms and simply saying 'here's your membership card' isn't enough to empower a new generation. "If you want students to be interested, you need to make them feel they can be involved, and explain how that will benefit them," she explains. "Being dedicated to your cause is really important, and also modeling that is important. For instance, telling them about experiences I had going to different conferences and being able to represent our school...that got a lot of students interested."

Including DC/UOIT, there are six Ontario schools offering student membership through tuition/ancillary fees. The others are St. Clair College, Humber College/University of New Brunswick, Queen's University, Trent University, and the CARE Centre for Internationally Educated Nurses.

"I would like to see every nursing student regard RNAO as part of their education. So much of what the association does in terms of practice and policy is going to affect them when they begin practising," says Daniel Lau, RNAO's director of membership and services. "It's important for them to see the value of their professional body in action early on, and to be part of the process that shapes nursing and health-care policies."

Kathleen Kerr shares this view. She's in her third year of nursing at Toronto's Ryerson University. She'd love to see this happen in the collaborative program with George Brown and Centennial colleges. It's complicated, she admits, because there are three sites. But she's willing to put in the effort.

"First years are always asking why this is important to them now," she says of her conversations as membership representative for RNAO's Nursing Students of Ontario (NSO) interest group. "My biggest selling point is the knowledge they're going to gain." But she doesn't pressure anyone to get involved right away. "If you want to be a part of eight interest groups because you're just interested...that's totally fine," she tells colleagues, suggesting they decide later what they want to focus their attention on.

Kerr admits she's come up against some resistance. Some students argue that membership with the Canadian Nursing Students Association (CNSA) is already included in their tuition, so why include membership with another association? "They're both competing for that student voice, but I don't think it should be a competition." CNSA and NSO are different groups with different mandates, she tells naysayers. "I don't think people understand we each have our roles and they can be synergistic."

Synergy and collaboration are at the heart of an initiative of this nature, Gilbert, Cochrane and Kerr agree.

Gilbert says: "This is a way to get students together...increasing their confidence that even though they're still studying, they do have a voice, and RNAO does listen to that voice." **RN**

To find out more about the benefits of student membership, visit www.RNAO.ca/studentbenefits

KIMBERLEY KEARSEY IS MANAGING EDITOR AT RNAO.

POLICY AT WORK

What will the profession look like in 2030? How will the RN role grow?

RNAO's board of directors will soon issue a blueprint that answers these and other questions, and will be seeking your input. Stay tuned for details on how you can contribute and help the association create a new vision for the future of nursing.

RNAO provides input on strategy to improve seniors' care

A strategy on how to help seniors stay healthy and live at home longer will be unveiled this fall by the Ministry of Health. It will explore several approaches, including expanding house calls, increasing access to home care services, and establishing care co-ordinators to work with health-care providers so seniors receive appropriate care when they leave the hospital.

RNAO weighed in with recommendations it hopes will be considered in the overall strategy. Among them: increase access to home care and other support services so more seniors can remain in their homes; and change the focus of the 'doctor's house call' initiative to ensure NPs and RNs make the majority of visits, consulting with physicians when necessary.

RNAO believes that enhancing nurses' roles makes more sense from a fiscal perspective, and leads to system efficiencies that allow physicians more time to look after patients with complex care needs.

RNAO is also calling on the government to:

- Advance the mental, physical and social health outcomes of seniors by applying a seniors-centred approach to the strategy.
- Adopt evidence-based policies and practices, including RNAO's best practice guidelines (BPG) to improve seniors' care and outcomes. In particular, the BPGs that focus on preventing falls, elder abuse, foot and other pressure ulcers, pain and constipation. As well, BPGs that promote client-centred care and chronic disease management.

RNAO cautioned the government to re-think a health promotion component of the plan that would advise seniors on the benefits of "eating well and exercising regularly." The assumption that all seniors have equal access to nutritious food is misguided. RNAO wants to see a more comprehensive approach that addresses the social and environmental determinants of health.

To download the submission, visit www.RNAO.ca/seniorstrategy

Responding to PC vision for health care

Tim Hudak, Leader of Ontario's Progressive Conservative party, unveiled his vision for health care in early September. *Paths to Prosperity* contains recommendations that he says will address red tape, spending concerns, and access issues cited by patients. An RNAO review of the document finds kudos is in order for Hudak starting the conversation on how to decrease duplication and improve system integration by doing away with Community Care Access Centres (CCAC). However, RNAO rejects Hudak's idea to replace the province's 14 Local Health Integration Networks (LHIN) with 30 to 40 regional 'health hubs,' operated by existing hospitals. This gives the system keys to the most expensive sector, and places a greater focus on illness care rather than health promotion and disease prevention. RNAO also rejects Hudak's plan to place physicians in charge of primary care committees, for fear this will negatively impact on attempts to advance interprofessional care.

Nurses say yes to expanding scope of pharmacists

RNAO is throwing its support behind pharmacists who want to see their scope of practice expanded to include giving flu shots, treating minor ailments such as skin rashes, and providing advice to help people manage chronic diseases such as diabetes. The association sent a letter of support to the head of the Ontario College of Pharmacists (OCP) in August. While ensuring health-care providers work to their full potential is a long-held view of the association, RNAO's letter outlined a few concerns before granting complete support. The association wants the OCP to ensure patients are not paying out-of-pocket expenses for increased access to pharmacists. RNAO also wants assurances that expanded powers apply only to pharmacists, and not to pharmacy technicians. **RN**

LEGAL COLUMN

BY JANE LETTON

Accessing patient records

IF YOU'RE NOT IN THE PATIENT'S CIRCLE OF CARE, DON'T EVEN GO THERE.

KAREN* WAS CURIOUS AND WANTED to know more about interesting diagnoses and treatment options. While working at an Ontario hospital, she reviewed thousands of patient files outside her circle of care. She thought she was acting within the law because the Personal Health Information Protection Act (PHIPA) allows access and use of personal health information for the purpose of risk and error management. Karen believed access to patient files was allowed if the action was meant to improve or maintain quality of care, quality of any related programs or services, or to educate professionals.

Do you think Karen was acting within the law? If you answer yes, think again. Karen was terminated for her actions.

While her union challenged the termination, the arbitrator found Karen violated her obligations and PHIPA, and her termination was upheld. In this case, the nurse accessed several thousand patient records, but in the eyes of labour arbitrators, employers, and the College of Nurses of Ontario (CNO), whether it's thousands or just one, it is a violation.

Compromising patient privacy is met with zero tolerance by most arbitrators, even if the number of breaches is minimal and for a short period of time. In another Ontario case, a nurse's termination was upheld after she accessed the records of four individuals outside her circle of care, even though access on each lasted between two and six seconds.

Nurses are cautioned not to think access to personal information is okay if the person is a family member, and that implied or express consent is acceptable grounds to look at confidential files. One Ontario nurse was terminated for such a breach. The arbitrator found there were compelling mitigating circumstances regarding the nature of care she provided, and she was reinstated. However, she did not receive back pay, which is a substantial penalty, as several months passed between the nurse's termination and the arbitrator's decision. It is not unusual for a grievance arbitration to take more than a year, sometimes several years, to complete.

> "COMPROMISING PATIENT PRIVACY IS MET WITH ZERO TOLERANCE BY MOST ARBITRATORS, EVEN IF THE NUMBER OF BREACHES IS MINIMAL AND FOR A SHORT PERIOD OF TIME."

CNO's *Therapeutic Nurse-Client Relationship* standard permits nurses to provide care for family members as an unregulated care provider in the home. A nurse is acting in a professional capacity at work. As such, the standards require that nurses refrain from working in a nursing role for friends or family members, unless no other care provider is available. When it comes to the records of friends or family members, even if you have the express consent, politely direct them to their health-care provider. The same applies to your own records. You may not only risk termination, but also being reported to CNO by your employer.

CNO is concerned with ensuring nurses comply with the legislation and with its confidentiality and privacy standard. It takes compliance with the law very seriously and developed its standard to be in accord with Ontario's privacy legislation, which states nurses "access information for her/his clients only and not (access) information for which there is no professional purpose."

Another Ontario nurse accessed the records of four individuals who were not her clients, including the daughter of her common-law spouse. She later shared that patient information with her spouse. As a result, she received a one-month suspension, was required to complete remediation activities, and had to meet with a regulatory expert. She also had to provide a copy of CNO's decision to her employer, who had to agree to advise the college of any breaches of CNO standards for 12 months.

Non-unionized nurses who inappropriately access patient records do not have the benefit of grieving a termination, and may find their employment terminated with cause. While you can challenge the dismissal through civil action or a complaint under the *Employment Standards Act*, such an action is unlikely to succeed when the termination is the result of a breach of both legislation and professional standards.

Employers know that mistakes happen. If you accidentally access a record that you should not have accessed, immediately notify a manager both verbally and in writing. Health-care providers regularly audit their systems and nurses are in a much better position if full disclosure is offered immediately, rather than trying to explain weeks, even months, down the road what happened, and why you didn't disclose. **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 TWO YEARS.

** Pseudonyms have been used to protect privacy.*

CALENDAR

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Oct. 30 Kingston
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Nov. 7 Owen Sound

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Oct. 31 Kingston
Nov. 7 Sudbury
For information, phnsummit@rnao.ca or 1-800-567-4527 ext. 214

NOVEMBER

November 1

LEADERSHIP FOR NEW GRADS WORKSHOP
Toronto, Ontario

November 18-23

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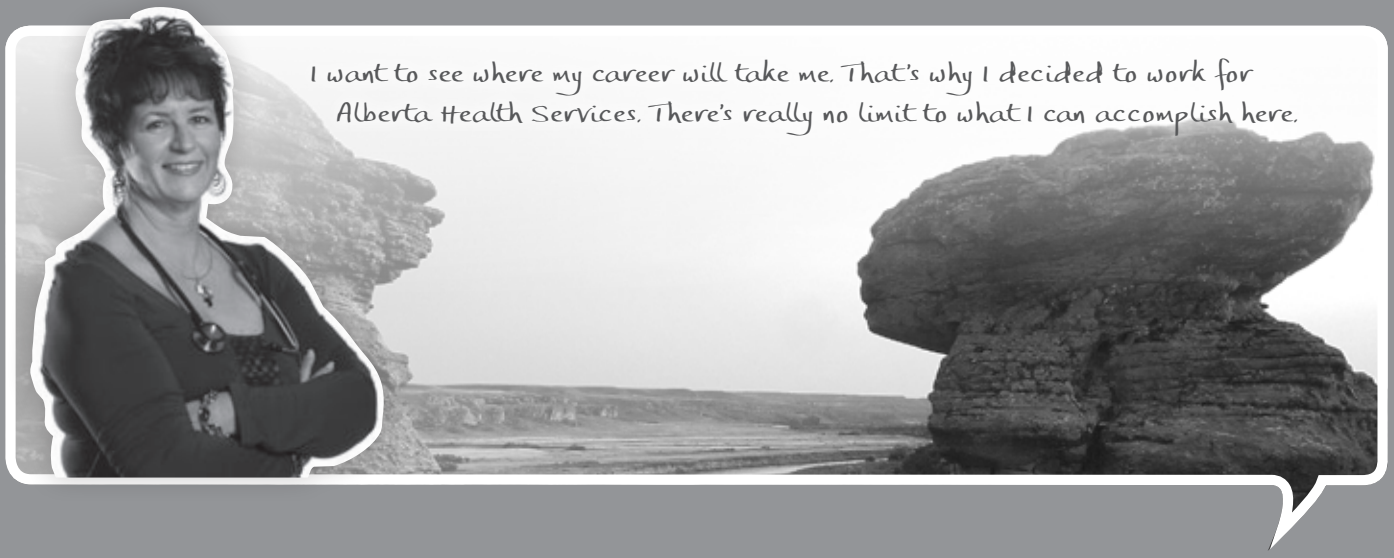

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IN THE END

BY SANDRA RAQUEL RIVAS

ILLUSTRATION: DAVE BARNES

What nursing means to me…

I DID NOT ENTER NURSING BECAUSE IT WAS A CALLING OR PASSION. I MADE A practical decision based on my circumstances. It was 1988 and I was a new immigrant, struggling with a language barrier and limited resources. I took a counsellor's advice and headed to college rather than university. I left behind my long-held dream to become a physicist or seismologist and selected nursing because it seemed to be the best fit for me.

In 1993, I graduated with honours from Toronto's Seneca College. When I started working, and someone praised me for choosing this profession, I felt like an impostor. Many of my colleagues talked about nursing as the only thing they ever wanted to do. That was not the case for me. It wasn't long before I began thinking about university again, and contemplating another career path. However, the demands of starting a family made it impossible, and I was drawn back into nursing. A decade into my career, practice standards changed and I realized I needed to return to school for my degree. While working and studying in 2004, life presented me with an incident that transformed my outlook.

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

I was a staff nurse on the surgical unit at a Mississauga hospital when I met the woman who would help me to finally embrace my profession. She needed surgery: stat. We sprung into action, but nobody – including me – was there with her, supporting her spirit and will to live. In the midst of the commotion, she grabbed my hand and looked up at me. I looked back at the person inside her sick body; at her silent stare and inner strength. In that moment, she made me understand that my place was exactly there, holding her hand and allowing her to hold mine. Something felt different inside of me. She looked at me, smiled, and said 'thank you.'

At that moment in my career, I finally understood what it meant to be a nurse. This patient taught me to look inside myself for the strength I did not know I had as a nurse. She allowed me to value my practice and empowered me to enjoy what I do. Before this experience, I was reluctant to accept nursing as a great profession. There are so many struggles we still face as a profession. But I no longer let that define what I do.

I now strive to focus on the positive things that nursing offers me, and on the patients I am privileged to meet. I do not remember the name of that woman who held my hand, but I remember in her time of need, she had the strength to say 'thank you.' That has stayed with me through the years. Nurses are lucky to offer support to other human beings, and to be able to make a difference in their patients' lives, even if it is for one moment in time. **RN**

SANDRA RAQUEL RIVAS IS A STAFF NURSE IN THE OPERATING ROOM AT HALTON HEALTHCARE'S MILTON SITE.

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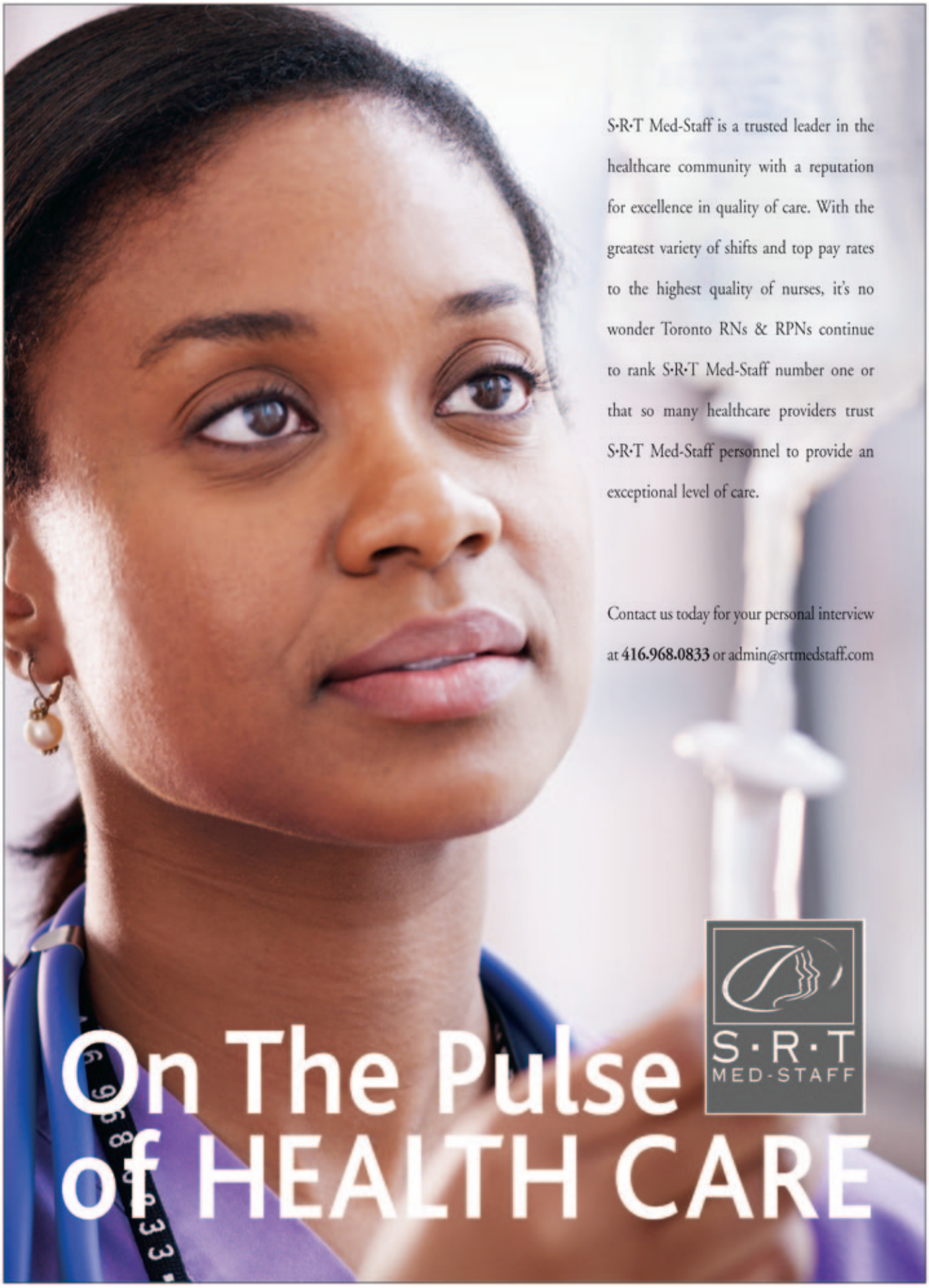
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