JULY/AUGUST 2012

REGISTERED NURSE JOURNAL

The case against restraints

Alternatives improve patient safety and quality of life.

PM 40006768

What they didn't teach you in nursing school • Primary care nursing task force

NOTICE OF

2013 AGM

HILTON TORONTO
FRIDAY, APRIL 12, 2013

Take notice that an annual general meeting (AGM) of the Registered Nurses' Association of Ontario (hereinafter referred to as 'association') will be held at the Hilton Toronto hotel commencing the evening of Thursday, April 11 for the following purposes:

- To hold elections of directors as provided for in the bylaws of the association
- To appoint auditors
- To present and consider the financial statements of the association (including the balance sheet as of October 31, 2012, a statement of income and expenditures for the period ending October 31, 2012, and the report of the auditors of the association thereon) for the fiscal year of the association ended October 31, 2012
- To consider such further and other business as may properly come before annual and general meetings or any adjournment or adjournments thereof

By order of RNAO Board of Directors

Rhonda Seidman-Carlson, RN, MN
President

Call for Resolutions

Deadline: Monday, December 10, 2012 at 1700 hours (5:00 p.m.)

Do you want to shape nursing and health care? As a member of your professional association you can put forward resolutions for ratification at RNAO's AGM. By submitting resolutions, you are giving RNAO a mandate to speak on behalf of all members. It is important to bring forward pressing nursing, health and social issues that affect nurses' daily lives, and the public. RNAO members represent many facets of nursing within the health-care system. You play a vital role in ensuring nurses' voices are heard, and in advancing healthy public policy across the province and elsewhere. RNAO encourages individual members, chapters, regions without chapters and interest groups to submit resolutions for ratification at the 2013 AGM. Please send materials to Penny Lamanna, board affairs co-ordinator, at plamanna@rnao.ca.

Important to note:

- resolutions must bear the signature(s) of RNAO member(s) in good standing for 2013
- when submitting a resolution, it should be noted in writing that the submitter(s) has "no known conflict of interest"
- a *maximum* one-page backgrounder must accompany each resolution (this one page is to INCLUDE references) and the font used must be no smaller than Arial 10 or Times New Roman 11. Margins on this one page must also be reasonable, e.g. an absolute minimum of 0.7 margin all around
- all resolutions will be reviewed by the Provincial Resolutions Committee

For clarity of purpose and precision in the wording, we recommend each resolution include no more than three 'Whereas' and preferably only one, but never more than two, 'Therefore Be It Resolved.' Please refer to the following successful 2012 resolution for guidance:

WHEREAS Fetal Alcohol Spectrum Disorder (FASD) is the most common developmental disability in Canada affecting 1 per cent of the population and costing Canadians 5.3 billion dollars/year; and

WHEREAS Fetal Alcohol Spectrum Disorder (FASD) can be prevented by increasing awareness about the dangers of drinking in pregnancy, screening women for alcohol use in pregnancy, and supporting women with appropriate services to eliminate alcohol use in pregnancy; and

WHEREAS individuals with FASD can function effectively in communities with adequately funded diagnostic services and evidence-based, appropriate interventions, services and supports;

THEREFORE BE IT RESOLVED that RNAO advocate for an integrated strategy in Ontario to address FASD that includes: prevention, best practice screening guidelines for addictions, diagnosis, evidence-based interventions, and appropriate support services for individuals and families.

Call for Nominations 2013–2015 RNAO Board of Directors

Deadline: Monday, December 10, 2012 at 1700 hours (5:00 p.m.)

As your professional association, RNAO is committed to speaking out for nursing, speaking out for health. **YOUR** talent, expertise and activism are vital to our success. For the 2013 year, RNAO is seeking nominees for:

- President-Elect
- Regional Representatives for all 12 Regions

In accordance with the 2012 RNAO Policies, members of the following **RNAO board committees** shall *be appointed by the Board of Directors*. Nominees are sought for the following vacancies:

- Provincial Nominations Committee (2 RN vacancies)
- Provincial Resolutions Committee (2 RN vacancies)

Joining as a member of an RNAO board committee affords you an opportunity to become more involved and engaged in the work of RNAO.

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

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

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EDITOR'S NOTE KIMBERLEY KEARSEY

Impressions in practice

I ALWAYS ENJOY DOING THE SUMMER issue of *Registered Nurse Journal* because I get to work directly with members to edit their stories for our summer collection (pg. 16). This year, the communications department received some great submissions about the real world of nursing, and the surprises that novice RNs did not see coming when they finished their exams and began their careers.

I think it's safe to say there are always surprises in the real world – no matter what your chosen profession might be. We live in a protected bubble when we're students, learning about things that are predictable, neatly packaged, and probable. If we experience anything "unexpected" in the classroom, it's likely a pop quiz or a surprise question on the exam that seems to come out of nowhere.

"Unexpected" in real-world nursing affects patients and families, and can sometimes mean the difference between life and death. As you will see in this issue, so much of nursing is about these surprise experiences, and the resulting revelation that each curve ball in your career is meant to strengthen your resolve that this is the right profession for you.

Laura Wagner (pg. 13) was herself a student when she had her first experience with restraints as a nursing assistant in a long-term care home. She admits she was too inexperienced to know the impact of their use on her patient's safety and quality of life. The experience was a turning point that led her to research restraint use, and to focus some of her career on creating better safety measures in nursing homes.

This issue of the *Journal* is filled with stories that can be described as either a turning point or a surprise. I'm not certain there's actually a difference. Whatever the descriptor, these have clearly left a lasting impression on the nurses who have lived the experience. And the communications team hopes they leave a lasting impression on you. **RN**

Connecting with nurses, creating change

Welcome to summer – hot, hazy and humid. I hope you are enjoying the weather, keeping well hydrated and, of course, using sunblock.

What an experience it has been representing Ontario RNs as your new president these past few months. In June, I was in Vancouver attending the Canadian Nurses Association's board meeting and annual general meeting. Many issues, ideas and solutions came out of these meetings. I was relieved and pleased to hear how policy, research and practice experts from right across this country agree we must focus on optimizing the role of the registered nurse at the point of care. This aligns 100 per cent with the key focus for my presidency.

You may be aware (see *Policy at Work*, pg 23) that RNAO has released an outstanding report on maximizing and expanding the roles of RNs and RPNs who work in primary care (community health centres, family health teams, NP-led clinics, and physicians' offices). The document provides key directions for ensuring nurses in this sector work to their full scope. As well, the report is a blueprint for other sectors in health care. The Joint Provincial Nursing Committee, of which I am a member alongside our CEO Doris Grinspun, has established a sub-committee on optimization of the RN and RPN roles and it will focus first on the recommendations related to community care. This committee will have representation from all sectors in health care, education, unions and professional associations. It will apply the RNAO blueprint and process, and recommend clear directions to enhance access to what patients need: the services of a registered nurse.

I'd like to know how your workplace is optimizing the role of the RN. Do you see areas for improvement, and ways that RNAO can help you make those improvements? What are the barriers to making this happen? Or what are you doing successfully that others might benefit from? Please share your stories with me at rseidman-carlson@RNAO.ca. It's through open discussion and the sharing of ideas that we all learn from one another.

> "I was relieved and pleased to hear how policy, research and practice experts from across this country agree we must focus on optimizing the role of the RN at the point of care."

This notion of sharing brings me to the CNA meetings I attended this summer in Vancouver, where nurses from across the country came together for an annual meeting of the minds. The board of CNA passed a motion based on the federal government's Bill C-38, the omnibus bill that included nearly 800 other legislative changes cloaked in what they're referring to as a budget bill. At RNAO, and across the country, people are outraged that debate over the legislation, open presentation of proposed changes to the bill – democracy in essence – has been undermined. To that end, the board at CNA unanimously passed a motion that our national organization actively lobby the nurses and people of Canada to stop this dismantling of our democratic values.

CNA's National Expert Commission report was also released in June. It provides clear direction (beyond recommendation) on how to transform Canada's health-care system. I encourage you to visit www.cna-aiic.ca to read the report, find out about the commission, and provide your suggestions on how to make this vision a reality.

As your president, I have the honour of representing you at CNA meetings by taking a seat at the board table. Twenty resolutions came forward for discussion this year at the AGM. RNAO submitted eight that focused on: the role of public health nurses in schools; the need to improve access to Suboxone treatment; improving health and health care in correctional facilities; maximizing and expanding the role of the primary care nurse; stopping Prime Minister Harper's cuts to immigrant health programs; advocating for a reduction on the jobs deficit; risk mitigation strategies; and supporting the rural and remote nursing workforce. Each of our resolutions was passed at the AGM.

Representing you nationally through CNA, and provincially through the RNAO board, allows me to connect with members, which is important to me. I also connect with you through this column in the *Journal*. The response to my first column (May/June) was overwhelming. Members across the province wrote to express support, and to provide both encouragement and ideas. Thank you to everyone who took the time to connect with me. Please keep doing that. **RN**

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

For more detailed information about RNAO's resolutions to CNA, visit www.RNAO.ca/CNAresolutions2012

Nurses shape health and healthy work environments – everywhere

PART 2 OF 3

Pride, leadership and strength best describe my feelings as I presented the Toronto Public Health (TPH) Unit with its Best Practice Spotlight Organization (BPSO) designation at its June 25 Board of Health meeting at Toronto's City Hall. Applauding with zest were about 100 attendees, including TPH board members, senior staff, and the general public. TPH has worked diligently for its BPSO designation, and throughout the process of achieving it, has created a healthy work environment for its nurses. Implementation of RNAO's best practice guidelines (BPG) has positively impacted on clients' health outcomes and has inspired its workforce like nothing else before. For me, this June presentation was the culmination of three years of leadership in action at TPH, which I know will continue.

RNAO's BPSO program began in 2003. Since its inception, 60 organizations representing 298 health-care sites have joined as BPSOs. Whether these are provincial, national or international, they are true leaders in shaping clinical practice and healthy workplaces. They are reinvigorating their nursing workforces by providing the tools (clinical BPGs) and supports (healthy work environment BPGs and education) that nurses need to show leadership through evidence-based practice. Nothing motivates nurses more than evidence that they are making a difference. Through this initiative, there's no question they are.

Fairview Mennonite Home, a long-term care facility in Cambridge, is another recent BPSO designate. This organization has successfully implemented five BPGs. It has shown excellence in shaping clinical care and healthy work environments with its unwavering commitment to best practices at all levels of the organization. Administration and staff have all been involved in implementing the BPGs and have also partnered with the Nursing Best Practices Research Unit to conduct research. Nurses have participated in RNAO's champions and advanced clinical practice fellowships programs, and have attended summer institutes to network and further advance their best practices utilization. As the old saying goes: "the proof is in the pudding," and the deliverables are clear for this organization. It has seen a reduction in residents' falls, incontinence and depression. Its involvement in the BPSO program has also resulted in more engaged staff, decreased workloads, and proven cost savings for the organization.

The word is out: Implementation of RNAO BPGs is leading to better outcomes at the individual, organizational and system levels – in every sector, region and country.

St. Elizabeth Health Care has set the bar very high with its long-standing commitment to enriching nursing practice and creating healthy work environments through the implementation of RNAO BPGs in the community sector. It is amongst RNAO's founding BPSOs. It began its journey in 2003, and has not eased up on its efforts, producing incredible results which have been well disseminated through presentations at high profile conferences and in peer-reviewed publications. Its commitment has led to exceptional client experiences, as well as nursing engagement and leadership in community health care. In addition, St. Elizabeth promotes workplace health and wellness, offering discounted gym memberships, onsite fitness and weight loss programs, massage therapy, wellness workshops and company-wide challenges and funding to help local teams meet their wellness goals.

> "THE WORD IS OUT: IMPLEMENTATION OF RNAO BPGs IS LEADING TO BETTER OUTCOMES AT THE INDIVIDUAL, ORGANIZATIONAL AND SYSTEM LEVELS — IN EVERY SECTOR, REGION AND COUNTRY."

It's thrilling to see so much great work being done in public health, long-term care and home health care. There also is so much going on in hospital care, but no space for me to expand in this column, as I want to briefly share how we at RNAO home office walk the walk. We have social events, regular staff meetings, and annual retreats. The September staff retreat will be dedicated to reviewing the results of a staff survey – developed by a small team representing each department at home office and based on our healthy work environment BPGs. It will allow everyone to contribute their thoughts on ways to sustain what's positive in our workplace, and find solutions to our challenges.

The conversation is happening everywhere, and that is extraordinary – a sure first step to optimizing health and healthy work environments for all. **RN**

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

Part 3 of this series will focus on how nurses are shaping system change. Watch for it in our next issue.

 BY MELISSA DI COSTANZO

Better Health through group care

NP SUSAN SHEA DISCOVERS WHAT HAPPENS WHEN PEOPLE COME TOGETHER TO SHARE SIMILAR HEALTH EXPERIENCES.

For most people, visiting a nurse practitioner for help with one – or a number of – chronic conditions doesn't evoke images of sitting in a room with 16 others who are also looking for help from the same NP.

Ninety-nine-year-old Elizabeth* found herself in that very situation when she became a patient at the Smiths Falls Better Health Project (BHP), a clinic operated by Rideau Community Health Services (RCHS).

During her first group visit, Elizabeth announced she had no interest in attending. But by the third visit, the elderly woman apologized, saying group care was the best health care she had ever received.

It was a moment that made NP Susan Shea realize she was "in the right place, doing the right thing."

The BHP, under the clinical leadership of Shea, began in May 2011, shortly after news broke that 5,000 people in Smiths Falls and surrounding towns did not have access to a primary care provider. Orphaned patients were forced to visit the hospital with a cough or to renew medications, overwhelming the ER.

The NP-led clinic ran for one year, thanks to one-time funding from the South East Local Health Integration Network, and aimed to relieve some of these pressures. Priority was given to people who had complex chronic conditions and those who were regularly hospitalized or who routinely visited the ER. It was staffed by two part-time physicians, an RN, an RPN, two part-time pharmacists, a medical secretary, a social worker and Shea, who was the clinical facilitator.

Over a period of 12 months, Shea and the BHP team were able to make a difference in 600 people's lives.

Three things you don't know about Susan Shea:

1. She loves to sing.
2. She lived and worked as an NP in Hawaii for 10 years early in her career.
3. Her favourite place is her family's cottage in Lanark Highlands.

What attracted Shea to this clinic was the unique patient intake method: grouping people together allowed them to share stories and experiences. It also meant practitioners could teach self-management skills to more than one person at a time. "It was quite a unique thing," she says.

The clinic was set up to allow for three group visits over a six-week period. When the six weeks were up, patients were transferred to a permanent health-care provider, and a new group would begin the cycle.

Clients signed confidentiality agreements and brought their significant others. Between these visits, clients also had one-on-one time with the NP or physician. They went through a detailed review of their past medical history, completed a physical exam, and underwent various preventative assessments. They could also ask questions that pertained to their personal situations.

"Groups can be very powerful in influencing health change," says Shea. Patients often shared stories about similar conditions, or an approach to self care they had success with, such as a drug they used to quit smoking.

When she started, Shea was just as inexperienced as her clients when it came to group visits. She was excited for the program to start, but admits she was anxious to see how patients would respond. She was pleasantly surprised.

Her eyes tear up when she thinks of the woman who began to cry during her first group visit, recalling her plight to find a provider. "It was very rewarding to see that people who were so desperate for care, and so ill, were pleased and grateful they were finally getting the care that they needed," she says.

When the BHP wrapped up this past June, Shea and the rest of the team applied the lessons they had learned to other group visits. A diabetes group was launched by RCHS, and a chronic disease management clinic is in the works. Shea says group visits are less traditional, but highly effective. She plans to spread the word by penning articles on their value because "we have to look at new ways of providing high-quality care."

After the BHP ended, Shea accepted a position at the Children's Hospital of Eastern Ontario. She meets with teens and their families individually and in groups for counseling, treatment and education, bringing her experience with group care to a younger demographic.

Shea says her work at the BHP made her recall a time early in her career when she wasn't quite sure nursing was for her. In fact, she was contemplating a teaching career. With some encouragement from family, she began to learn about nursing's emphasis on caring for patients holistically.

"It's the most rewarding career I could ever hope for." **RN**

MELISSA DI COSTANZO IS STAFF WRITER FOR RNAO.

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

NURSING IN TH

Nurses rally for refugees

The federal government's plan to cut health-care benefits available to refugees and refugee claimants has prompted an outcry from Ontario's health-care community. On June 18, nurses and other health professionals rallied in over a dozen Canadian cities, calling on Prime Minister Stephen Harper to halt the proposed roll-back of the Interim Federal Health Program (IFHP), which allows refugees to access health benefits. Changes to the IFHP occurred July 1, leaving many refugees only able to access emergency care and care for chronic conditions that are considered a risk to public safety. Before the changes took effect, however, an amendment was made, shielding government-assisted refugees from the cuts. Although welcome, many other refugees will be denied access to critical health services.

Grace Rosete-Lasala, a nurse practitioner at the Multicultural Council in Windsor, said her organization will work with clients to determine if they qualify for drug coverage under other benefit plans, but admits the cuts "will definitely affect their health."

Lynda Monik, CEO of the Windsor Essex Community Health Centre, said provincially funded hospitals will end up taking care of sicker patients who go to the ER when something is wrong. Private health coverage is not an option for many refugees, she added.

Federal Immigration Minister Jason Kenney says the changes will save the government about $100 million over five years, and will deter abuse of the system. Nurses say the changes will end up costing the health-care system more in the long run. (*The Windsor Star*, June 19)

RNAO research assistant Grace Suva (right) joins an unknown protester at the Toronto rally (June 18) to oppose cuts to Canada's Interim Federal Health Program.

Bill ignores citizens' right to a voice

On June 4, RNAO joined the *Black Out Speak Out* campaign, darkening its website in a symbolic protest of the federal government's Bill C-38. President **Rhonda Seidman-Carlson** offered her view and RNAO's judgment on the bill's proposed changes to Wingham, Ontario radio host Bill Townsend.

"We are looking at prevention," she said. "RNAO's concern is people don't know what's being proposed. This bill has more than 70 federal laws and regulations and a lack of debate means things can be seriously changed without people being aware of it."

The *Black Out Speak Out* campaign, endorsed by over 300 organizations, "...is a symbol of being denied access to information. People don't have a voice," Seidman-Carlson said. (*The Talkshow CKNX/ AM920*, June 4)

Call for expansion of nurses' duties

On June 28, a nursing task force, launched by RNAO in the fall of 2011 (see *Policy at Work*, pg 23, for more detailed information), issued its groundbreaking report with recommendations for expanding the duties and influence of primary care RNs and RPNs so they are working to their full capacity. RNAO CEO and co-chair of the task force, **Doris Grinspun**, spoke to Hamilton, Ontario radio host Bill Kelly.

"What we want is for RNs and RPNs to be used to their absolute full scope of practice so that Ontarians can get same-day access to primary care," she said. "We can achieve same-day access for the public within six months if the recommendations of this report are put to use by government and employers." (*The Bill Kelly Show, AM 900*, June 29)

Hospital reduces error through technology

Linda Bisonette, Vice President, Patient Care Services, and Chief Nursing Executive at Perth and Smiths Falls District Hospital, said the recent purchase of 45 new intravenous pumps, or so-called 'smart pumps,' will lead to an overall reduction in medication errors. The pumps, which have a dose error reduction system, warn users of inaccurate

E NEWS

BY CLAIRE O'KEEFFE

medication orders and calculate errors or incorrect programming that compromises patient safety. "This new technology will go a long way in assisting the nurse in the administration of medication," Bisonette told *Smiths Falls EMC* (June 21). "This type of system is essential for a hospital to deter medication errors," **Nancy Massie**, a patient care manager on the medical/surgical unit, added. "Initial feedback from the clinical and medical staff is quite positive."

Three Oaks Shelter aims to expand

Pat Culhane, a registered nurse for 46 years, a city councilor for five years, and the victim of violence at the hands of her partner when she was in her 20s, offered a supportive voice to Quinte's Three Oaks Shelter as it campaigned this past June for Second Stage Housing in Belleville. The shelter is trying to raise $1.3 million for a building project for abused women and their children. Second Stage Housing will include onsite supports and eight apartment-style units. The ultimate goal is to help victimized women achieve independence. "I'm living proof, that with the right help, and a lot of strength, you can live a healthy, independent life free from violence and control," Culhane told the crowd that gathered for the campaign launch. "The situation has not improved – it has deteriorated. Finding affordable housing is a desperate, desperate undertaking," she said, but with a note of hope: "This is a war that can be won." (*Quinte EMC*, June 7)

RN and Belleville city councilor Pat Culhane supports the need for housing to help abused women and children achieve independence.

Nurses teach 'Preparation for Breastfeeding' class

Family health nurse and RNAO member, **Cindy Hutchinson**, helped to facilitate a 'Preparation for Breastfeeding' class at her local health unit on June 18. New or expecting moms and their partners attending the class at Haliburton, Kawartha, Pine Ridge District Health Unit were offered tips on breastfeeding, and information about support and resources available to new mothers in the area. "We talk about getting off to a good start and show (moms) ways to prevent and overcome difficulties. Being in a class with other parents who are planning to breastfeed also lets (moms) share advice and experiences that can make the adjustment easier for everyone," said Hutchinson. Studies have shown that babies who are breastfed have a reduced risk of developing diabetes, asthma, ear and upper respiratory infections. Breastfeeding has also been found to help mothers protect against breast and ovarian cancer, as well as weak bones. (*Kawartha Lakes This Week*, June 7)

Caring in Kenya

Kristie Soder, a nursing student at Queen's University in Kingston, said she owes her two-week adventure in Kenya, "an absolutely beautiful country," to a newspaper article about a group called Canadian Nurses for Africa (CNFA). The group is made up of nurses from the Burlington-Hamilton area who have travelled to Africa to work in rural clinics. Soder travelled to Kakamega, Kenya, on April 27 to help set up a clinic. For two weeks, 12 nurses, with Soder as the lone nursing student, saw many patients who walked for hours to receive care. One lone traveler was four years old, she recalled. "We saw a lot of people who had malaria, and quite a few who had typhoid," Soder said. "Cases that you would never in a million years see in Canada because we have methods that can prevent things of that sort." Although it was "...heartbreaking" and "...hard to see," Soder said she'll go back to Africa the first chance she gets. (*Kingston Whig-Standard*, June 8)

Queen's University nursing student Kristie Soder travelled to Kenya in April to help set up clinics for the people in and around Kakamega.

NURSING IN THE NEWS

OUT AND ABOUT

ESSEX CHAPTER CELEBRATES GRADS

More than 200 nursing students writing their CRNE exams on June 6 in Windsor were met afterward by RNAO Essex chapter secretary Pat McKay (right) and her fellow University of Windsor faculty member Kathy Pfaff, who handed out congratulatory tags and chocolate syringes in recognition of reaching a milestone moment on the journey to becoming an RN.

ART WALK IN SARNIA

In early June, RNAO's Lambton chapter set up a booth at Sarnia's Art Walk 2012, connecting with community members and offering information about nursing. The group labelled jars with pressing issues such as poverty, unemployment, mental health and the environment, asking passersby to drop a donation in the jar that they felt was most pressing. Given an increase in teen suicide in Sarnia, the mental health jar contained the most donations, which were then presented to a representative of a suicide awareness group by chapter president Sonja Gould (left).

MINISTER OF STATE COMES TO RNAO

Alice Wong, Canada's Minister of State for Seniors (right), visited RNAO home office June 15, World Elder Abuse Awareness Day, to announce funding to create a BPG on elder abuse. The federal government also funded the association's Prevention of Elder Abuse Centres of Excellence (PEACE) project in 2011. In March 2012, the federal government introduced amendments to the Criminal Code that impose stricter sentencing for individuals convicted of elder abuse.

Nurse saves limb with larvae

An unorthodox suggestion made by RN **Rose Raizman**, a wound specialist at Scarborough's Rouge Valley Centenary Hospital, was the principal reason 59-year-old Polish immigrant Waclaw Tyszkiewicz's infected right foot was not amputated. Tyszkiewicz, a diabetic, cut a callus off his foot with a knife, which triggered an infection. "We were pretty concerned about his leg," Raizman said, noting she had seen flesh wounds like this before, but his was severe. She suggested placing live maggots into the wound, leaving them to feast on the dead flesh. Specially-bred blowfly maggots were flown in from California. The treatment lasted three weeks, with 800 maggots feasting on the dead flesh for up to 36 hours, once each week. "It's beautiful," Tyszkiewicz said. "Every time I see Rose I say thanks, thanks, thanks, a million times thanks...she saved my (foot)." (*Toronto Star*, July 9) **RN**

LETTER TO THE EDITOR

RNAO member **Anne MacPhail**, *public health chair of the Kingston Coalition for Active Transportation, wrote an editorial for* The Kingston Whig-Standard *on June 23. She thanked and congratulated residents for participating in* Active Commute to Work Week. *Following is an edited excerpt:*

Trading keys for kudos

Active Commute to Work Week helped promote the national *Commuter Challenge*, encouraging people to leave their vehicles at home and walk, cycle, take transit, carpool or telecommute. Kingston had 29 organizations and 333 registered commuters logging their data. This helped us come in first place in Canada amongst other cities with comparable populations. Residents who left their cars at home traveled 29,000 kilometres, saved 4,430 kilograms in greenhouse gas emissions, and saved 1,740 litres of fuel in one week.

As one of the organizers, I am very proud of Kingstonians and many of our neighbours who live outside the city and work in Kingston who really stepped up and contributed to healthier and more sustainable transportation. One commuter and her six-year-old son rode their bicycles, and she pulled her four-year-old in a chariot behind her. She and her kids had a great time together. Another avid cyclist approached a number of fellow cyclists at work, and organized a company-wide ride that invited anyone interested in joining to meet en route.

Anne MacPhail
Kingston, Ontario

NURSING NOTES

And the SAGE goes to…

Winners of the Service Awards for Geriatric Excellence (SAGE) for 2012 were announced in May. RNAO members Susan Oates and Maureen Montemuro were among the 60 nominees. Oates, a nurse for more than four decades, was recognized for being a champion of elder care though leadership in policy and program development, education and research at St. Mary's Hospital in Kitchener. Montemuro, who works at St. Peter's Hospital, Hamilton Health Sciences, is a highly regarded mentor to colleagues. Many students credit her for their decision to specialize in geriatrics after working with her. She is also known for never faltering from her philosophy that bedside care should always be guided by the best research evidence.

Susan Oates (centre) receives her award from last year's winner and fellow RNAO member Anne Pizzacalla (right).

Maureen Montemuro proudly displays her award for geriatric excellence.

Three London RNs get president's awards

Three RNAO members were recognized in June with President's Awards from London Health Sciences Centre (LHSC). Susan Collins, a recently retired nurse practitioner in the cancer program, received recognition for her work with patients. Karen Peters, who specializes in hemodialysis, was acknowledged for her leadership and its impact on the organization. And Pat Doyle-Pettypiece, an NP in clinical neurological sciences, was awarded for her work with colleagues. The names of all three nurses have been engraved on a plaque in the President's Gallery at the Victoria and University sites of LHSC.

Registration regulations change at CNO

The College of Nurses of Ontario (CNO) quietly notified its members – online – of changes to registration regulations that will take effect January 2013. Details are available for review on CNO's homepage (www.cno.org). There are two modifications that are expected to have a significant impact. New declaration requirements dictate that renewing members must declare they have practised nursing in Ontario within the last three years. If they have not, they must register in the new, non-practising class, or resign. New evidence of practice requirements are also expected of NPs, who must declare they have practised in a clinical capacity within the previous three years. If they have not, they will be issued a general class certificate, and will have to meet specific requirements to return to the extended class. Other changes include: new jurisprudence exam; expanded conduct and character requirements; and new rules affecting dual registrants.

Prestigious CNA Order goes to Toronto researcher

University of Toronto nursing professor and RNAO member Ellen Hodnett was one of five individuals to receive Orders of Merit from the Canadian Nurses Association during its biennial convention in Vancouver in June. Hodnett's work has led to new legislation in Uruguay and Brazil, and new practice guidelines in Canada, the U.K. and the U.S., focusing on continuous support during childbirth. "We know the nurses honoured tonight are a shining example, for their colleagues and the profession's future generation, to ensure we are the change we want to see in Canada's health-care system," CNA CEO Rachel Bard said. "It is a privilege and a pleasure to present these nurses with well-deserved honours," CNA Immediate Past-President Judith Shamian added. "I also wish to thank them for their dedication to the nursing profession. I do so on behalf of Canadians because these women are truly helping improve the health of our nation."

University of Toronto nursing professor and RNAO member Ellen Hodnett.

Help for incontinence sufferers

Women who suffer from urinary incontinence can now refer to an RNAO-backed decision aid booklet to learn more about the causes, useful resources, solution options, and to understand the condition in order to make more informed decisions. Reviewed by a group of 25 Ontario-based nurse continence advisors, and women with and without incontinence, the booklet helps sufferers – predominantly women between 40 and 65 – to deal with a sometimes humiliating and often distressing problem that can have a significant effect on their quality of life. Urinary incontinence is a common problem that can arise when a sufferer coughs, laughs, sneezes, or jogs, or when there's not enough time to reach the washroom. To find out more, visit www.RNAO.ca/incontinencedecisionaid. **RN**

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

A last resort

Alternatives to restraint use improve safety and quality of life.

BY MELISSA DI COSTANZO

Laura Wagner first used a restraint in the mid-90s, when she was a nursing student. She admits being unaware of the potential for injury – or even death – that could be linked to the device.

At the time, Wagner was working as a nursing assistant at a long-term care home in the U.S. She was caring for an elderly woman who was being restrained daily in a recliner with a tray strapped across her midsection (a Geri-Chair). The woman had Alzheimer's, and a tendency to become anxious and restless. Nobody really knew that she could walk, Wagner recalls.

Back then, Wagner says she felt impartial about restraints, and accepted them as a part of this woman's routine care. She looks back and realizes she was too inexperienced to know otherwise.

After a failed attempt to fit the woman's large Geri-Chair into a small washroom, Wagner discovered the resident could walk, if given the opportunity. She began taking her on routine strolls to the dining hall and back, and up and down the hallway. Wagner noticed the woman became less agitated. "She didn't need to be restrained as much as a result of (regular walking)," she says. In fact, Wagner was able to help her become more mobile and free from restraints for longer periods of time. This experience made the young nurse realize just how detrimental restraints can be to a patient's safety and quality of life, and just how easy it can be for a nurse to make a difference.

Wagner's decision to walk with her patient was a small act with significant consequences. Without even realizing it, Wagner discovered a viable alternative to restraints. She says all nurses should look for alternatives to restraints whenever possible, and RNAO agrees. In fact, this is the central focus of one of the association's newest best practice guidelines (BPG), *Promoting Safety: Alternative Approaches to the Use of Restraints*.

Today, Wagner is a geriatric nurse practitioner who has dedicated part of her career to research on restraint use and improving safety in nursing homes. She co-led the panel of experts that created RNAO's BPG, and is an adjunct nursing scientist specializing in patient safety with Toronto's Baycrest health centre. Wagner lives in the U.S., working as an assistant professor at the San Francisco campus of the University of California's School of Nursing.

"We need to think creatively about how we can maintain that person's safety without having to restrain them"

LAURA WAGNER

She explains some of the history behind the BPG, developed shortly after a coroner's inquest into the death of Jeffrey James, a patient at the Centre for Addiction and Mental Health (CAMH) in Toronto. After five days of being physically restrained in July 2005, James collapsed, and later died in hospital after a blood clot formed in his leg. CAMH has since implemented a restraint prevention initiative that includes a revised policy that focuses on restraint prevention and use of restraints as a last resort in emergency situations. CAMH has also focused on staff training and the use of alternatives.

RNAO Past-President Wendy Fucile provided testimony and a nursing perspective at the inquest into James' death. When it wrapped up, recommendations were set out by the province's coroner, including one that RNAO develop a BPG to address restraints, accompanied by an educational program. That BPG – released in March 2012 – focuses on all patients – including those with mental illness – who are at risk of harming themselves or others.

Frances Lankin, a former NDP MPP and Minister of Health, was invited to review the guideline in light of her personal experience that ultimately led to a significant change in provincial legislation. Lankin's mother, Frances Ollmann, was physically and chemically restrained in 2000 against her family's request. The experience affected Lankin deeply. She championed a private member's bill that aimed to regulate the use of restraints, and in 2001, the provincial government enacted the *Patient Restraints Minimization Act*.

A decade later, RNAO's BPG is a reference guide for nurses, other health professionals, and health-care organizations. It recommends the use of restraints only when all other options have been exhausted. It's meant to "challenge health-care providers to think about how we can provide care that's safer," says Wagner. "We're not thinking enough about some of the alternatives that could be used."

According to Wagner, health-care professionals use or rely on restraints for three reasons: (1) they are thought to prevent falls – though she notes there is ample research that states this is not the case; (2) to keep a person from acting out and kicking, hitting, or shoving staff or other patients – though the evidence is also clear that restraints can increase aggressive behaviours; and (3) to prevent interference with treatment such as feeding or breathing tubes. Methods of restraint use are not limited to physical means such as waist belts or mitt restraints. There are also chemical restraints, such as antipsychotic medications, and environmental restraints, like seclusion. All are commonly used in long-term care homes, acute care, and mental health settings. According to a 2011 report from the Canadian Institute for Health Information, almost 25 per cent of people admitted to mental health beds in Ontario are restrained physically or with medication, predominantly to maintain safety of clients and staff.

Wagner says most nurses can likely recall an experience with restraints. These experiences are tough to forget, especially given restraints can contribute to physical and mental decline. They are physically demeaning, and can cause pressure ulcers, strangulation, and death, she says. In fact, studies cited in another RNAO BPG, *Prevention of Falls and Fall Injuries in the Older Adult,* suggest that restraints can actually increase the severity of falls.

Some nurses rely on restraints because they're the easiest option during a busy work day, Wagner adds. And families can also factor into the decision. Relatives don't want their loved one to fall, for example, and don't understand that people can be harmed from restraint use: "We need to think creatively about how we can maintain a person's safety without having to restrain them."

Wagner recalls the story of a man who used to perform in the circus. As he aged, he began falling often in his long-term care home, acquiring head injuries. His family wanted him to maintain an active lifestyle, so the interdisciplinary team began to discuss options, eventually allowing him to wear a helmet and use a walker. "He was able to walk around, and his family was grateful he had an active end of life," she says. "That is the whole point of the guideline: to look at examples and alternatives."

Athina Perivolaris, an advanced practice nurse at CAMH, co-led the organization's three-year prevention of restraints and seclusion initiative. She also co-led the BPG panel with Wagner, and says that before alternatives can be considered, it is essential for nurses to develop therapeutic relationships with their patients. This will help them understand patient histories, and build trust. "…In a crisis situation, it's hard to figure out what alternative might be effective…" if you don't have that background knowledge, she says. Nurturing a rapport with the client will allow the patient and the nurse to discuss viable coping strategies and an individualized care plan.

"When you're coming into a health-care environment, you're looking to receive care that will offer you a feeling of safety, security and that will support you in your recovery," she says. "Any time a restraint is used, it can negatively impact on the therapeutic relationship."

RESTRAINT RISKS

Restraint use can lead to unfavourable – sometimes fatal – outcomes. Nurses should keep the following complications in mind when considering the use of restraints:

PHYSICAL

- bruising
- pain
- reduced muscle strength
- skin tears
- joint contractures
- severe bedsores
- aspiration
- constipation or urinary incontinence
- circulatory changes
- loss of movement
- dehydration and loss of appetite
- pulmonary emboli
- risk of self-injury
- asphyxia
- strangulation

COGNITIVE

- isolation
- increased stress or trauma
- confusion
- agitation
- frustration
- guilt
- loss of autonomy and dignity
- anger
- fear
- depression
- changes in self-image
- sleep disorders

Source: RNAO BPG *Promoting Safety: Alternative Approaches to the Use of Restraints*

Perivolaris notes that what works for one client, may not work for another. "We have a professional, moral, and ethical obligation to continue to explore options, to implement them and evaluate them," she says. "You don't develop an individualized plan...that will last for the entire span of care. It's an ongoing, dynamic, collaborative process between the health-care team, the client and the family."

Perivolaris acknowledges that it's not always easy to find alternative options to restraint use. Practitioners may focus too much on the point at which troubling behaviour has already escalated. When care providers are "only looking at that end point, then you really have a limited opportunity to consider or even implement alternatives," she says. The BPG focuses on the earlier stages of intervening, and collaboration with clients and families to come up with alternatives that are supportive.

Alternatives such as flesh-coloured "sleeves" camouflage tubing, which means the patient is less likely to tug or pull at it. Another example is an alarm that beeps when a patient or resident stands up or moves. Strategies that support regular expression of emotion – such as writing in a journal and listening to music – can also be effective. If nurses "start early in the process, there's a greater possibility of potential alternatives that we might want to explore and evaluate," Perivolaris says.

If a restraint is used, learning from each and every instance is also key, she adds. A debriefing with staff to address what could be put in place to prevent future use of a restraint, or a meeting with the client, will help health professionals to better understand the patient perspective.

Perivolaris says guidance from all levels of management, in addition to clear policies, is essential when health-care organizations begin steering the focus away from regular restraint use as an intervention for safety. "You can have a really good policy, but it's just a policy unless you also have (strong leadership) to support the expectations in the policy," she says.

Irmajean Bajnok, Director of RNAO's BPG Program, agrees, and says leadership begins from the moment an organization decides to implement the guideline. "You need the organization's leaders to appreciate that this type of best practice may mean other supports, such as equipment and additional human resources, may need to be deployed." Nurses, she says, welcome the BPG because it helps them think outside the box. "The guideline builds on skills the nurse can use as an alternative to restraints, because it's often in the nurses' hands as to whether restraints are used or not. We hope this guideline helps RNs to move away from using restraints as a part of their care."

There isn't any definitive statistical information on exactly how many patients in Ontario have died as a result of being restrained. In addition to the story of Jeffrey James, there is the story of Toronto senior Florence Rose Coxon, who died in 2008 while struggling to free herself from a belt that was fixed around her waist in a wheelchair. It was reported she died of asphyxiation. These stories are powerful reminders of what can go wrong, and why restraints should be a last resort. In each case, the facilities where these individuals lived were responsible for revising their restraint policies. Some employers, however, have chosen to proactively revise their policies in advance of tragedy.

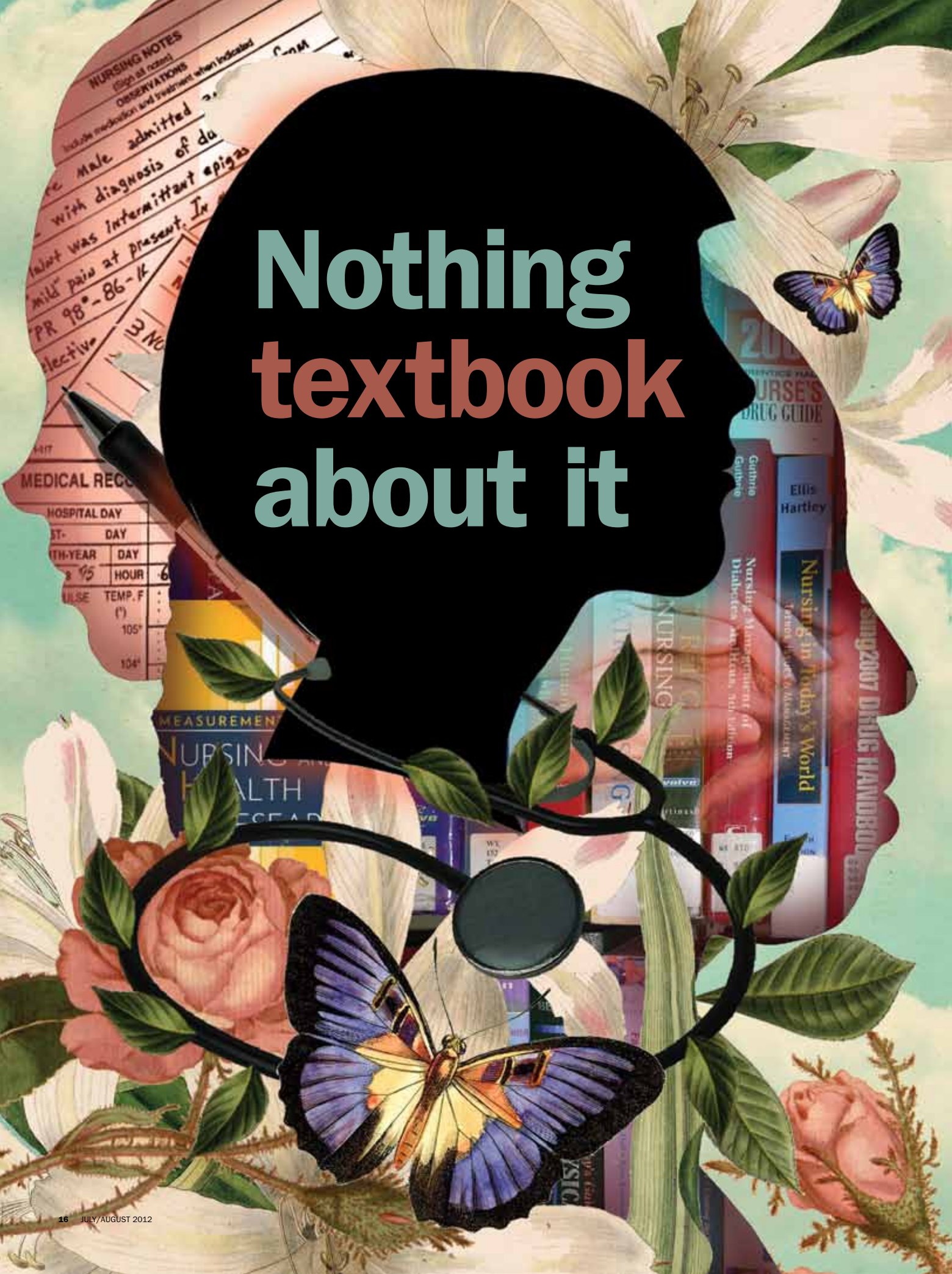
The Ottawa Hospital, for instance, is in the midst of adjusting its *Least Restraint, Last Resort* policy to ensure it reflects the most up-to-date research. It is implementing RNAO's BPG, with a goal to improve patient safety, satisfaction and quality care, says Lisa Freeman, corporate co-ordinator of nursing best practices.

To ensure least restraint is always top-of-mind, Freeman says the hospital is focusing on the revision of its policy to create and promote additional alternatives to restraint use. Another priority will be to specifically address high risk patients – like the mental health population.

Patients, she says, are "the centre of our care, and we don't want them to be in restraints."

Wagner hopes the BPG will bring more attention to the issue, and encourage nurses to share their success stories and innovative alternatives. This, she says, will "help evolve the movement and (persuade practitioners) to consider how we can think differently about this topic." **RN**

MELISSA DI COSTANZO IS STAFF WRITER AT RNAO



Nothing textbook about it

Each summer, our July/August issue of *RNJ* features your stories. This year, we asked you to write about some of the lessons you have taken away from daily nursing practice that you could not have picked up in a textbook or learned in nursing school. Your stories offer touching, humourous, and thought-provoking reflections about your day-to-day nursing practice. We're confident these stories will resonate with you, whether you are a new or recent grad, or a veteran RN with a couple of decades of experience behind you. Your encounters with patients and colleagues provide meaning and context for your work. Thanks to all of you who shared a piece of your own personal history with us...

ILLUSTRATIONS BY JOHN WEBSTER / i2iART.COM
EDITED BY KIMBERLEY KEARSEY

Textbooks and tutorials didn't teach me…

How to hold the hand of a dying woman

Fatima-Angela M. Caluag, Kitchener, Ontario

During a semester-long placement on the medicine and palliative care unit at Stratford General Hospital earlier this year, I met patients whose stays were much longer than the typical acute care patient on another unit. Some showed progress, while others did not. Some would become palliative and die within a week. Others would suffer for much longer. I met Mrs. G during one of my first shifts. She was admitted for end-stage, cancer-related pain control. Mrs. G was a middle-aged woman, bedridden due to weakness, not a single hair left on her head. Her family was at her bedside each day and, eventually, a cot was set up in her room to allow members of her support system to remain like sentries while she slept.

One night shift, her call bell rang. For reasons unknown to me, her family was not there that particular night. Due to her health history, Mrs. G was under contact isolation. When I arrived at her doorway, I called to her that I was coming, and pulled on the requisite yellow gown and blue hospital gloves to protect against infectious disease. She told me her mouth was dry and sore, which I assumed was due to a decreased oral intake and her medication regime; a common issue with palliative patients.

After using a water-soaked oral sponge for a few minutes, I asked her if the water helped. She nodded. I asked if she would like me to apply more water. She shook her head, and her eyelids fluttered closed as if the effort from parting her lips had drained what little strength she had left. I turned away to dispose of the sponge, and when I turned back, I saw her hand raised, trembling ever so slightly.

"Can I get you something?" I asked as her fingers settled around my hand. When she did not immediately answer, I instinctively turned my hand over so I could reciprocate by grasping her fingers. I prompted, "Mrs. G?"Her eyes opened partially. Her voice was hoarse and barely above a whisper. "I just want you to hold my hand."

Those eight words conveyed the importance of touch with a depth and richness of humanity that a textbook never could. Nothing I studied in nursing school could have prepared me for the burning threat of tears that I blinked back, or my desperation that I could not, at that pivotal moment, take my glove off to hold her hand properly. Instead, I ran my rubber thumb back and forth over her knuckles to give some semblance of physical comfort. I still regret being unable to provide at least one brief reprieve with true touch and human warmth.

A few days later, Mrs. G died.

Textbooks and tutorials didn't teach me…

That advocacy is at the core of everything we do as nurses

Ildiko Nanai, Lindsay, Ontario

My graduating class at Seneca College was one of the last to complete the three-year diploma program before a four-year degree became mandatory in 2005. At first, I felt cheated and disappointed, but soon realized it didn't matter how many years I was in a nursing program; even four years would not have prepared me for all the other things I would learn outside of school.

What they didn't tell me during my three years of study was how crucial advocacy is, not only for patients but for nurses. This realization hit me when I became a correctional nurse. Correctional nursing is the fusion of the health-care system (nursing) with the legal system (corrections). Generally, nurses are expected to maintain professionalism at all times, provide care within their scope of practice, and advocate for patients without bias. This is a challenge in a regular health-care setting. In corrections, it's even harder.

Correctional nursing often goes unrecognized as a specialty by its governing body and the legal system. There is a general lack of awareness of its uniqueness. Judges, prosecutors, lawyers, and ombudsmen seem largely unaware of how health care happens within the correctional setting, and what the nurse's role entails. This lack of awareness and recognition means insufficient resources and support, which in turn poses a great challenge for the nurse who is expected to carry out her or his role effectively.

Security and health care: it's a delicate co-existence where safety and security always comes first, nursing second. In corrections, providing unbiased care is the easy part. Providing the right care requires creativity. We have seen an increase in the client population in corrections over the last 15 years. Educational in-services and support systems are vital. We need mental health nurses and psychologists, without whom we cannot advocate on our clients' behalf. How can a correctional nurse advocate for a client with mental illness in a system that focuses primarily on safety and security? How can a correctional nurse properly care for acutely medically ill clients without adequate staffing and resources? Advocacy is the key.

However, before we can advocate for our clients in corrections, we must first advocate for necessary changes for ourselves. We must be recognized and supported so that we can live up to our role to the full extent. It is our right. It is our duty. And it is what nursing is about.

"Those eight words conveyed the importance of touch with a depth and richness of humanity that a textbook never could." —Fatima-Angela M. Caluag

Textbooks and tutorials didn't teach me…

The power of hindsight, and the danger of naiveté

Renee Lehnen, Oakville, Ontario

I would have made a great midwife. However, the admissions office at Ryerson University informed me in a tersely worded letter in 1999 that it didn't share my opinion. Dreams crushed, I turned to Plan B and began the diploma nursing program at George Brown College the following year. I consoled myself with reminders that nursing would be portable, in demand, and reasonably well paid. Thirty-three years old, with two children, a bachelor's degree in environmental studies, and an overseas teaching career behind me, I had a shockingly adolescent, cardboard cut-out view of nursing. I figured my mom is a nurse; how hard can it be? The surprises began in my first week of nursing school, and they've been mocking my naivety ever since.

Surprise #1: The diploma nursing courses were more difficult than the courses I had taken for my bachelor's degree. Our instructors actually expected us to prepare for class and clinical because the information was important.

Surprise #2: A seemingly simple task such as dispensing medication while the call bell rings, and a worried family member tugs at your sleeve, requires the mental discipline of a Buddhist master.

Surprise #3: Caring for someone who is dealing with a health crisis, or facing death, is every bit as rewarding as helping a woman give birth. I am humbled that I ever thought otherwise.

Surprise #4: The sheer breadth of opportunity in this profession is staggering. Since graduating in 2002, I have worked in medical/surgical, home care and primary care. There is no excuse for boredom in nursing. Change is simply a professional development course and resume update away.

Surprise #5: The camaraderie among nurses. Working a night shift, particularly when Murphy's Law asserts itself and trouble finds the team, is like combat. I imagine soldiers feeling the same admiration and kinship for each other that I feel for my co-workers.

Surprise #6: If a catheter bag is not locked off properly, and urine pools on the floor, the resulting mess is surprisingly sticky.

I would never have learned these things if not for front-line nursing.

Textbooks and tutorials didn't teach me…

The true value of family centred care and the support RNs offer in the NICU

Monica Jacela-Dhaliwal, Toronto, Ontario

After four years of nursing school, I gained the fundamental knowledge and understood the clinical guidelines that would direct my practice, including the principles of family centred care. However, six years of clinical experience in both the pediatric and neonatal settings has enriched my practice with valuable life lessons. I now understand that therapeutic relationships with families cannot be taught; they can only be nurtured through experience. And it is through my experiences that I am now able to truly understand the complexities of providing family centred care.

When I first started my practice on the neonatal intensive care unit at The Hospital for Sick Children in 2010, I was very focused on providing acute clinical care. At times, I questioned parental motives in continuing care versus withdrawing life-sustaining medical therapy when a baby's prognosis was poor. These ethical dilemmas made me question my own beliefs and values as a professional. When do health-care professionals intervene and advocate for the decision to withdraw or continue life-sustaining medical therapy if limitation of intensive intervention is in the best interest of the baby, but against parental wishes? For the first year of my practice, I did not understand how the interdisciplinary team came to these important decisions. I saw the baby separate from the family. I witnessed the baby struggling to survive, undergoing countless invasive procedures, and, at times, did not feel I was able to provide family centred care because I felt unable to empower the child, or support the baby in a way that would respect the baby's well-being and quality of life.

I've since learned that the epitome of neonatal nursing is family centred care. I am finally able to take a step back and understand family coping mechanisms, and the integral role the interdisciplinary team has in fostering family understanding and peace.

I realize there are situations that call for the health-care team to provide a family *time* to cope and come to terms with the acute situation. In return, families feel empowered to utilize positive coping skills. At the end of the day, it is the family that must cope with the loss of their child; or alternatively, the prospect of having a child with chronic illness or disability.

It was not school, but my clinical experience that taught me family centred care is about facilitating resiliency within the family to deal with the hardships of life. Nurses have the opportunity to be a pillar of support when people face the death of their baby, or the prospect of their child developing chronic illness or disability. Nurses empower families so they are able to cope with other situations; navigate the health-care system; and create a network of supports within their community. That is the true influence of nurses in providing family centred care in the NICU.

"Six years of clinical experience in both the pediatric and neonatal settings has enriched my practice with valuable life lessons." —Monica Jacela-Dhaliwal

Textbooks and tutorials didn't teach me…

That I have as much to learn from patients as they have to learn from me

Bev Chambers, Kingston, Ontario

In 1981, with four years of nursing experience under my belt, I applied to study midwifery in Scotland, a post-RN program that was not available in Ontario. In order to practise as a registered nurse in the UK, I had to work two months as a student on the surgical floor at Victoria Hospital in Kirkcaldy. I was not looking forward to this as I had already worked as an RN in Canada, but I did it because I was determined to go to midwifery school.

Scotland's health-care system was very different from what I was used to in Canada. In particular, Victoria Hospital's procedures were outdated; students were not allowed to read patient charts, and the head nurse (or Sister) would delegate tasks during the day. Although the nursing practices were unusual to me, I learned about the value of community among patients.

One day, I was assigned to care for eight older men in one room. They conversed with each other, and were a friendly lot. I could not always understand their Fife accent, and they teased me about my Canadian twang. I had to give one of the gentlemen a suppository. There was one large bathroom on the whole unit for all to share. It was quite a distance away, so I decided to put a commode by the bed and pull the curtains. The appropriate interval of time passed, and I returned. "Mr. D," I said. "Did the suppository work?" Another voice called out from the other side of the room. "Och aye," Mr. D's roommate shouted. "It's been heavy gunning over there, like the Battle of Waterloo!" Everyone doubled over with laughter, including Mr. D.

Each ward at Victoria Hospital had a small dining room, and patients who were ambulatory would walk to it, sit at its tables, eat together and have a grand chat. Often, the most mobile patients would sit with bedridden patients to keep them company, and sometimes help set up the tray.

After witnessing the degree to which patients were socializing, I realized the importance of laughter and a sense of community among patients. At school, I learned about therapeutic conversations with my patients, and how most of those conversations should have a serious purpose. Humour was not something I was encouraged to use. My experience in Scotland challenged that premise. We now know that laughter is beneficial, releases endorphins and helps reduce stress.

I never learned to encourage patients to mingle. Infection control was always foremost in my mind. But these patients demonstrated the value of peer support long before it was popular. The people of Scotland humbled me with their generosity and warmth. And they made me realize patients have far more to teach us than we can teach them.

Textbooks and tutorials didn't teach me…

That there is no place for self doubt in nursing

Olivia Boodram, Pickering, Ontario

I was doing my diploma in nursing at a college in Toronto in 1981. During an obstetrics/gynecology rotation for clinical practice, I was caring for post-partum moms at a large, urban hospital. We were expected to teach our patients about using a heat lamp to heal their episiotomy incision. However, I refused to do this and gave my rationale to my instructor at the time. In my view, the approach was potentially dangerous for someone to do without supervision. I also felt it was highly unlikely that a new mom would have a heat lamp at home to use after discharge. I felt the more effective way to promote healing of the incision was to keep the area clean, and to air the episiotomy at least three times throughout the day. My instructor did not share my opinion, and told me I would never be a good obstetrical nurse. I never understood the comment, or why she felt the need to say this to me, but I knew as soon as she said it that I would be an exceptional nurse who would provide the right care for my patients.

I did end up working in obstetrics, and have stayed true to myself and my beliefs. I started out in the nursery, and then moved to post-partum care. I have worked in a high-risk pregnancy setting and have developed and launched a new unit that monitors high risk clients as out-patients. I have been providing optimal care to each and every one of my patients for more than two decades.

This goes to show that you can never let someone's opinion get in the way of what you truly want to do and have a passion for. It also proves that students do have a voice and the ability to articulate well-thought-out and rational approaches to caring for patients.

If I ever cross paths with that instructor again, I'll have to thank her for making me realize that I have so much to offer the health-care system.

Textbooks and tutorials didn't teach me…

That there are boundaries in practice, just as there are between countries

Nancy Sinclair, Cambridge, Ontario

It's been more than three decades since I was a new grad, but I've told this story to my nursing students several times. I graduated at a time when nursing jobs were scarce in Canada, so many of us packed up and moved to Florida to practise. The transition (most of us were young women) was huge. New independence. A new country. A new health-care system. A new practice. Back in school, we didn't talk about the change from student to grad, or the transition shock that has now been researched so well. I worked in maternity, and on my unit, the clients were either public (socially assisted clients of the midwives), or private (paying clients of the doctors). The public clients were in the four-bed wards, while the private clients were in the semi-private or private rooms across the hall from each other. One evening, a young mom in her teens, a client of one of the midwives, and a mom with whom I had established a good nurse-client relationship, told me she was craving chocolate. As a fellow chocoholic, I completely understood the craving and said I would get her a chocolate bar while I was on break. The charge nurse found out I had done this and I was chastised for treating a public client better than a private client. The lessons were profound: about expectations in a two-tier health-care system; about treating clients with respect and dignity regardless of their ability to pay; and about my personal values and beliefs about client centred care.

Textbooks and tutorials didn't teach me…

The importance of being open to new experiences

Marie Salovaara, Powassan, Ontario

I graduated from nursing school as an RN in 1995. I had been an RPN for 10 years prior to that, so I knew a thing or two my classmates did not. I remember being in class and the other students wanting a day off from lessons to attend the school's winter carnival. How upset they were when we were told to be in class as usual that day; no time off would be allowed.

One of the first things you learn in nursing is that it is a 24/7 proposition. You better get used to missing out on things, including birthdays, Christmas, holidays and special events in the lives of your family and friends. This was a reality that surprised me when I first became a nurse. In fact, it came as a bit of a shock to be at work at 2:00 a.m., 3:00 a.m., and 4:00 a.m. instead of home in bed with the rest of the world. I don't remember that point ever really coming up in class. It's something I learned after a bit of time in the real world.

Early in my RN career, I also learned that sometimes you have to bend the rules. Not all scenarios fit into a neat little category. Allowing family to stay after visiting hours, having more people at the bedside than policy dictates, allowing special foods or treats that are not on the diet plan, and turning a blind eye now and again; these are all things you learn to expect as you go along and gain experience.

I have also learned when to speak up and to be vocal on behalf of my clients and when to keep my mouth shut. Nursing has been a wonderful ride for me. It's taken me places I never thought I would go, and I learn new things every day about my clients, co-workers and most of all myself. The key is to be open to new experiences, and never stop learning. **RN**

POLICY AT WORK

RNAO task force recommends expanded powers for nurses in primary care

Nurses who work in community health centres, on family health teams, in NP-led clinics, physicians' offices, and any other primary care setting, got a big boost from RNAO with the unveiling of a report that calls for expanded powers and concerted efforts to ensure RNs and RPNs are working to their maximum scope of practice, and that their scope be further expanded. Ontario has 4,285 nurses working in primary care (2,873 RNs and 1,412 RPNs). The *Provincial Primary Care Nursing Task Force* concluded these nurses are grossly underutilized. Its interprofessional report, released June 28, contains 20 recommendations to increase access to primary care. Among them:

- immediately appoint a committee, led by RNAO and the Ministry of Health and Long-Term Care, to roll out the task force recommendations
- issue directives to employers to utilize RNs and RPNs to their full scope of practice
- ensure RNs are empowered to conduct a broad range of clinical assessments and interventions, health education and chronic disease prevention and management
- authorize RNs to prescribe and dispense medications
- authorize RNs to identify and communicate a diagnosis
- authorize RNs to order diagnostic and lab tests
- ensure RPNs are empowered to take leadership roles in evidence-based health programs

Adopting the recommendations, the expert task force says, will enable people to access same-day care.

To download the full report, read the media release, or watch the media conference on YouTube, visit www.RNAO.ca/PCtaskforce

Judie Surridge, President of RNAO's Ontario Family Practice Nurses interest group (right) and RNAO CEO Doris Grinspun (second from right), co-chairs of the provincial expert task force that set out to maximize and expand the scope of practice of RNs and RPNs in primary care, lead a Queen's Park media conference on June 28. They are joined by RNAO President Rhonda Seidman-Carlson (second from left) and Nursing Policy Analyst Tim Lenartowych.

Long live Ontario's cosmetic pesticide ban

RNAO was among 12 health and environmental groups that signed a letter distributed to all Ontario MPPs on May 30. The letter urged provincial politicians to vote against an amendment to Bill 88, *An Act to Amend the Pesticides Act*, introduced by the Progressive Conservative Party. Had it passed, the amendment would have watered down the province's cosmetic pesticide law by permitting the use of lawn and garden chemicals. The groups pointed out that since the ban came into effect in 2009, concentrations of chemicals found in urban streams have dropped 97 per cent. In addition to RNAO, signatories included the Ontario Medical Association, Ontario College of Family Physicians, Canadian Association of Physicians for the Environment, Canadian Cancer Society, the David Suzuki Foundation, and Environmental Defense. The groups say the ban is successful because it protects human health and the environment at the same time. At the end of May, Bill 88 was voted down 51 to 34.

Nurses unite on issue of gender identity and expression

The province's Human Rights Code has extended protection to transgendered people, a move advocated and applauded by RNAO and members of its Rainbow Nursing Interest Group (RNIG). Politicians from all three provincial parties agreed to amend the code June 13 by adding the words 'gender identity' and 'gender expression.' RNAO CEO Doris Grinspun appeared before the government's *Standing Committee on Social Policy* on June 11 to voice nurses' unwavering support for the legislation. She pointed to several tragic responses to discrimination endured by transgendered persons, including suicide. She also noted a large number of transgendered people live below the poverty line. These are reasons to warrant better protection from discrimination, she said. RNAO and RNIG suggest the added protections will go a long way toward preventing discrimination against transgendered people looking for work, a place to live and health care. **RN**

Anna Moller
Georgian Bay
General Hospital

Michelle Acorn
Lakeridge Health

CARING FROM START TO

Enhanced powers for NPs translate into more timely,

Last fall, Tom* was admitted to the complex care unit at Georgian Bay General Hospital. He had suffered a stroke, but also had a number of other pre-existing health concerns. In the year preceding his admission, Tom had one foot amputated due to infection. He had coronary artery bypass surgery, after which he had congestive heart failure. And he suffered from hypertension and required appointments with an ophthalmologist in Toronto for diabetic retinopathy, an eye disease that causes blindness.

Nurse practitioner Anna Moller says she wasn't sure Tom was ever going home. "He had so many health concerns, we didn't even know if he was going to survive."

Moller co-ordinates care on the unit where Tom was admitted, and plays a key role on the interdisciplinary team. She was responsible for assessing Tom's emotional wellbeing, monitoring his liver and kidney diseases and ensuring treatment was provided quickly if he showed any signs of heart failure.

Moller says the team worked hard to make his dream of returning home possible. Five months after arriving, he was almost ready for discharge. But before he could go, Moller had to make sure the right community supports were in place. She connected him with a prosthetic podiatrist and a social worker, and made arrangements for his transportation to the ophthalmologist. She also referred him to a specialist who would treat his hypertension.

While NPs have long been involved in the process of preparing patients for discharge, they have not always been able to give the order to go home. July marked one year since that changed.

Prior to July 1, 2011, Ontario physicians delegated discharge orders to NPs by way of medical directives. Changes to Regulation 965 of the *Public Hospitals Act, 1990*, and subsequent regulatory changes by the College of Nurses of Ontario, now allow NPs to discharge hospital in-patients within their scope of practice. NPs with hospital privileges working in the community can also discharge their patients from hospital. RNAO and one of its expert groups, the Nurse Practitioners' Association of Ontario (NPAO), played a central role in these milestones, advocating for a number of years, and appearing before a government committees that examined the proposed changes. This advocacy led to the changes a year ago, and also to changes in July that allow NPs in Ontario to admit and treat in-patients, the first jurisdiction in North America to legally authorize these enhanced powers.

The changes have made a difference on many hospital units, such as surgical units. In the past, NPs may have had to wait hours for surgeons to finish operating before discharge orders could be issued. Being able to discharge a client means more timely care, which Moller says means faster access for those who are waiting for beds.

The less time a patient like Tom has to spend in hospital, the better, she adds, because a faster discharge also means less exposure to infection and superbugs such as MRSA and VRE. "Patients don't want to be in a hospital," she adds. "They want to be home."

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

Pam Hubley
Toronto's Hospital
for Sick Children

Vanessa Burkoski
London Health
Sciences Centre

FINISH

direct and efficient care, faster access, and greater accountability. **BY MELISSA DI COSTANZO**

Nationwide, Ontario has the largest number of NPs (2,064) working in the health-care system. These nurses have the authority to diagnose and treat illnesses, and, as of October 2011, can perform additional care acts and treatment procedures like setting/casting bone fractures and prescribing most medications – all without a medical directive.

RNAO and NPAO are thrilled with the legislative changes that took effect last year, and with the newest change – the ability to admit and treat in in-patient hospital units – that came into effect July 1. But both have always known that NPs are capable of taking on much more responsibility, and have advocated strenuously for the removal of roadblocks that prevent NPs from practising to their full scope. The work has paid off. In 2010, when the government announced NPs would eventually be able to discharge in-patients, it also confirmed they can order lab tests, diagnostics and treatments for hospital in-patients, and order insured services for their patients.

No one knows the value of these changes better than Michelle Acorn.

Acorn was president of NPAO when the province announced it was introducing admit and discharge changes that would enhance her capacity as an NP. "They formally recognized the role," she says. "They transformed health-care leadership and empowered nursing and advanced practice nursing."

Acorn says the enhanced abilities to admit, treat and discharge in-patients allow NPs to conduct their role in a more direct, efficient manner. And she has many examples to back up her claim.

Before the changes came into effect, Acorn could only provide in-patient care through doctors' orders. NPs working in emergency or an out-patient clinic didn't need medical directives for specific acts that were under their scope of practice, she explains. "But as soon as they went on the elevator to in-patient care, they had to have medical directives. Their practice was not even recognized." These barriers were frustrating, restrictive, and didn't recognize the knowledge and skill NPs possess, she says. The changes have "altered my practice significantly" because they've made work seamless, and cleared the red tape.

Acorn is the advanced practice nurse professional practice leader at Lakeridge Health in Durham region. Given her 13 years of experience as an NP, she was asked to co-chair an RNAO-led nurse practitioner expert panel, which was formed in response to the legislative changes to the role. The group was charged with developing a toolkit that provides documents, communication strategies, and presentations that assist with NP implementation and evaluation in hospitals.

Lakeridge, she says, has a strong NP presence. In fact, NPs began admitting and discharging patients five years ago because the hospital is a leader in maximizing the NP role in complex care and rehabilitation. They were doing so, however, under a shared care plan. This means Acorn and a physician would be listed on admit and discharge orders.

College of Nurses of Ontario numbers from 2011 indicate there were 900 primary care NP positions, compared to 122 in acute care, and 106 in emergency care. There were also 128 positions in geriatrics, 95 in education, and over 700 in other areas.

Beginning July 1 of this year, Acorn became the sole practitioner listed on an admission order, which she says translates to consistent care. Previously, NPs with no admitting privileges at a hospital would send their patient to the ER to be admitted. After being triaged, the patient would wait to be admitted by someone who wasn't familiar with their ongoing health needs. Now, an NP who is familiar with their client's history can admit and follow their care, in and out of the hospital.

This change also means NPs are more accountable to their patients, which causes Acorn to caution: just because you can, doesn't mean you should, unless you have the competency, knowledge and skill. She suggests nurses ask themselves: "what does it take to improve that competence to match my confidence?" This question can be answered with the help of nursing leadership, she says. Chief nursing executives and chief nursing officers must keep abreast of role changes to ensure everyone is on the same page and supported.

Changes to the position, Acorn says, have been "very rewarding." She has heard from many patients who have expressed gratitude for the timely care she has provided. "That's really the best measure, isn't it?" The proof also lies in the outcomes. In a 2008 survey of 91 patients at Lakeridge, 92 per cent said they received prompt treatment from an NP, and 97 per cent indicated an NP was easily accessible to patients and families. Ninety-two per cent of respondents said they were comfortable with their NP's care decisions.

Given it is a leader when it comes to enabling NPs to work to their full scope of practice, Lakeridge has had time to anticipate the changes, and has implemented the role of professional practice leader and lead NP (roles held by Acorn), and amended the bylaws, rules, regulations, policies and procedures to embrace full scope of practice. Other Ontario hospitals are still trying to understand what the change means for NPs in their facilities.

Toronto's Hospital for Sick Children is still thinking through the change, says Pam Hubley, Chief, Professional Practice and Nursing. It's safe to say, she adds, that the legislative changes have increased the authority of the NP to improve flow within the system.

Hubley, who was a member of RNAO's nurse practitioner expert panel, agrees that enhancements to the NP role will improve continuity of care and caregiver, particularly in remote and rural communities. The NP, who is often the main provider in a smaller town, can assess a patient in a community clinic, determine the need for hospital care, admit the patient to a local hospital, work with a team to provide care, and then discharge the patient.

"The power to admit, treat and discharge in in-patient hospital units is groundbreaking, and is optimizing the role of the NP in Ontario's health-care system," says RNAO CEO Doris Grinspun, who, like others, believes there is still more work that needs to be done. A handful of items under *Bill 179*, the *Regulated Health Professions Statute Law Amendment Act,* have not yet been proclaimed, including permitting NPs to: order CT scans; perform point-of-care lab tests; and apply forms of energy such as a defibrillator or electrocoagulation treatment.

NPs are one step closer to prescribing controlled substances. To read more, visit www.RNAO.ca/NPprescribing

Vanessa Burkoski, vice-president of professional practice and chief nursing executive at London Health Sciences Centre, co-chaired the NP expert panel alongside Acorn. The RNAO board member was also Ontario's provincial chief nursing officer (2007-2011). She is confident these items will be passed, especially with the powerful advocacy of RNAO and NPAO.

In the meantime, the panel, with the support of RNAO Nursing Policy Analyst Sara Clemens, will monitor, collect, and evaluate data related to patient and hospital outcomes as a result of NPs' enhanced abilities. The panel is developing a quality improvement project for hospitals that have adopted the discharge piece, and will identify processes that have led to success.

Burkoski says she will continue to advocate for the role because the future for NPs is brighter than ever. These changes acknowledge NPs' critical role in the system and "enable NPs to do what they've always done – take the lead in advocating for what patients need." **RN**

MELISSA DI COSTANZO IS STAFF WRITER AT RNAO

CALENDAR

SEPTEMBER

September 20–22
RNAO ASSEMBLY AND BOARD OF DIRECTORS MEETINGS
Hyatt Regency on King and RNAO home office
Toronto, Ontario

September 27
PRECEPTORSHIP FOR NURSES WORKSHOP
Toronto, Ontario

September 30–October 5
HEALTHY WORK ENVIRONMENTS INSTITUTE
Hockley Valley Resort
Orangeville, Ontario

OCTOBER

October 15
LEADERSHIP FOR NEW GRADS WORKSHOP
Windsor, Ontario

October 17–19
LONG-TERM CARE LEAGUE OF EXCELLENCE
Toronto, Ontario

Unless otherwise noted, please contact events@RNAO.ca or call 1-800-268-7199 for more information

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IN THE END

BY STEPHANIE GREENFIELD

What nursing means to me…

It is unusual for me to stop and think about the sweet sound of air moving in and out of my lungs. Clear. Uninterrupted. Beautiful. Most people – especially nurses – don't take the time to consider the very process that keeps them alive.

Working on a respiratory unit, I spend a lot of time listening to other people breathe. The sound is so different from my own breathing, of healthy lungs. Sometimes, there is no sound. Other times, I hear popping noises, shrill or squeaky sounds that are almost musical, or low-pitched echoes with a moaning quality. They're all unique and fascinating, but never good.

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

Carol* was 61 when we met. Suffering from chronic obstructive pulmonary disease (COPD), she told me she couldn't remember the last time she could really breathe. Weighing only 40 kilograms (89 lbs), her frail, emaciated appearance was enough to make anyone lose their breath. She had smoked for 40 years, but hadn't picked up a cigarette in over a week. I congratulated her. She strained to laugh. "It's funny," she told me. "For so long I said that smoking gave me a moment to stop and take a breath. It was my excuse to remove myself from all the hassles of life. Now…I can hardly breathe enough to stay alive." We both smiled at the irony, but weren't really amused.

John* was 64 when he was admitted with shortness of breath, extreme muscle weakness, and fatigue. Tests revealed cancer had metastasized to his spine, and possibly his bladder and kidneys. He spoke of how different things had been only a month-and-a-half before. He had just retired and was planning a trip to Florida. "But now," he said, shaking his head. "If only I had stopped and taken the time to be with my family…taken the time to breathe."

Today, I sit on the side of Brian's* bed. He has pulmonary fibrosis, and is re-learning how to breathe. Control creates calm, I tell him. We each place one hand on our upper chest, the other on our stomach. We inhale through our noses and feel our chests expand. Exhaling through pursed lips, we feel our stomachs deflate. We laugh. "I feel so silly," Tom says. "But, it is so nice to remember how to breathe." I nod in agreement, feeling strangely liberated.

After a busy morning, I look at my watch and wonder if I should take a lunch break or continue working. Rushing along the hall, I catch sight of Brian. He's practising the breathing exercises we reviewed only an hour earlier. He is laughing. I am amazed that he's found joy despite his health challenges. Smiling, I take a deep breath and head for lunch. **RN**

STEPHANIE GREENFIELD IS A STAFF NURSE AT GRAND RIVER HOSPITAL IN KITCHENER.

** Pseudonyms have been used to protect privacy.*

ILLUSTRATION: BLAIR KELLY

Alberta Health Services

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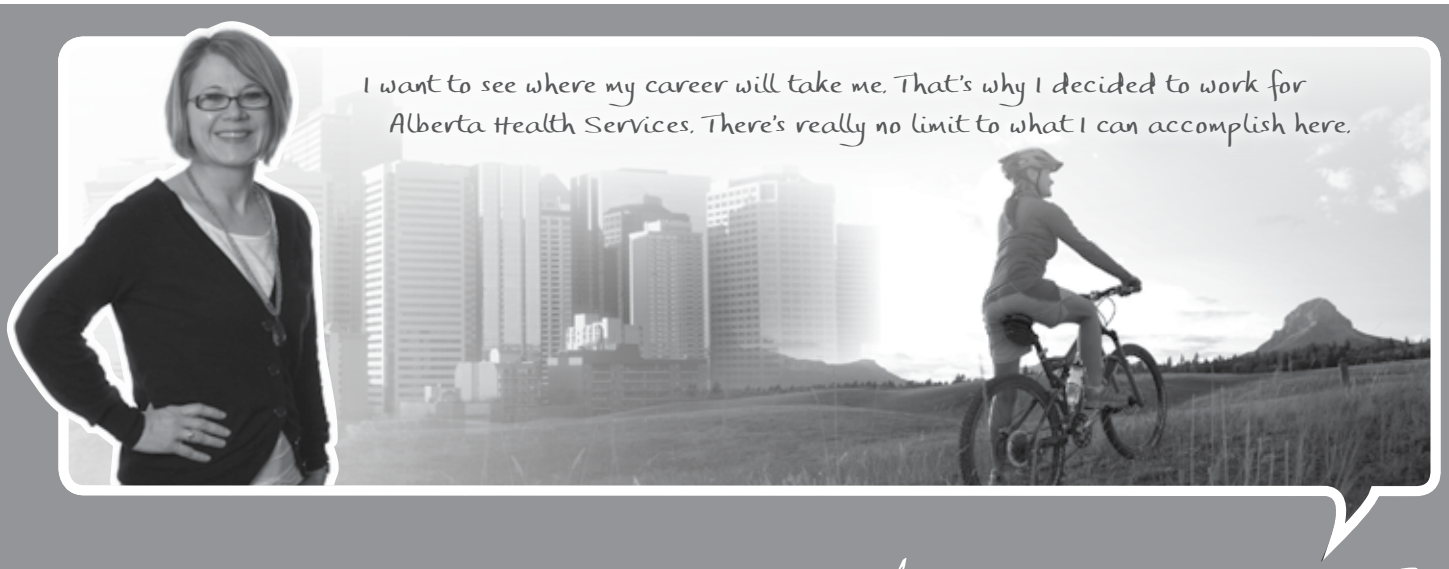

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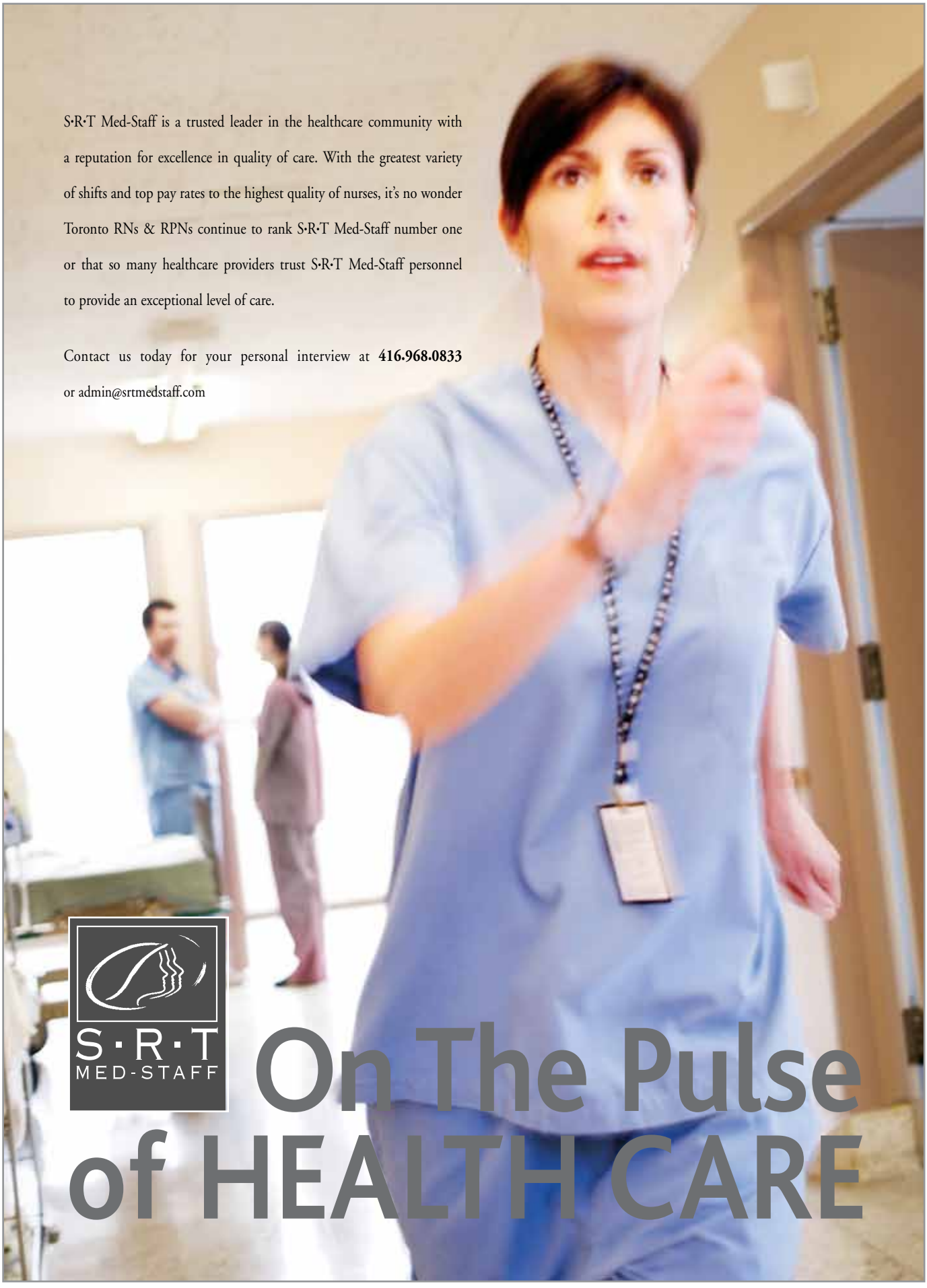

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