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Registered Nurse JOURNAL

September/October 2009

THE NURSE NEXT DOOR

Rural RNs like Melanie McBride care for their neighbours. The challenge is finding more people to work in small towns.

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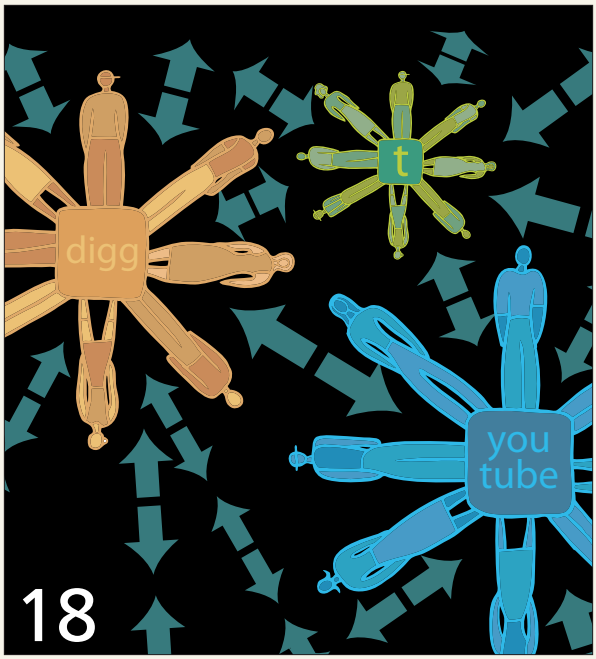

THE LINEUP

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Cover photography: Laura Arsie

FEATURES

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Coffee shop lineup sparks thoughts on rural nursing

This past summer, I found myself standing in a coffee shop in a small town in Ontario's cottage country searching for some caffeine before getting started on a four-day canoe trip. As I waited to place my order, I surveyed the crowd in the line. Between the sun-tanned tourists I spotted locals, too. Police officers, and a man wearing scrubs who I can only assume was a health-care professional working at the small hospital across the street. That got me thinking about how different working in a rural area must be from doing a shift in a big-city hospital. I wondered if the summer's surge of cottagers strains the town's health-care system, and about the hunting and fishing injuries that might regularly appear in the local emergency room, but are probably rare in Toronto.

Our cover feature takes a look at those differences. RNs who are working and living in small towns across Ontario describe the privilege of caring for their neighbours. They tell us about the breadth of skills you need to work in a place where you might find yourself re-assigned to the emergency room if it isn't busy on the floor where you usually work. They also talk about the creativity needed to recruit more RNs to join their ranks when they're competing against the pull of big-city life.

This issue also looks at the ingenuity that's needed to provide care far from home. Two RNs who've provided relief after some of the largest natural disasters in recent memory write about how they provided care in Thailand after the 2004 Indian Ocean tsunami. We also examine the way nurses – whether they're in Bangkok or Bruce County – can now share all the profession has to offer by using social media tools like Facebook and Twitter.

And as October and the RNAO membership year quickly wind to a close, we also take a look at resources the association provides to members everywhere. That includes the option to join a new interest group focused on wound care, and access to top-notch advice through the Legal Assistance Program (LAP). As you'll read on page 24, many RNs hope they'll never need LAP, but it can save their careers if they do. In fact, in some ways, LAP is like the hospitals in the towns near my canoe routes. I hope I'll never see the expertise of the RNs who work there from a patient's point of view. But if I do, I'm sure glad to know they're there.

Jill Scarrow
Acting Managing Editor

We want to hear from you
Please e-mail letters to letters@rnao.org
or fax 416-599-1926. Please limit responses to 150-250 words and include your name, credentials, hometown and telephone number.
RNAO reserves the right to edit letters for length and clarity.

RNAO membership offers rewards and the chance to give back

'Why should I join RNAO?' It's a question students and fellow RNs often ask me in the fall when the membership year is coming to a close. It's a good question, and there are many great answers.

Many of you have heard me say that when I graduated in 1974, I believed in the message of a professor who told me there was really no option other than to belong to my professional association - it was 'the right thing to do.' I first joined RNAO as a new nurse, and although I'm not so very new anymore, I have always believed in my teacher's message and renewed my membership each year.

Over the years, my RNAO membership has given me the opportunity to further my own education and offered me protection, advice and counsel during tougher times in my career. Belonging to RNAO has also given me the means to make substantive positive change in health care and nursing.

Through my RNAO work, I've been privileged to create a network of colleagues I can call on, consult with and share pleasures and anxieties. Many of these leaders have been mentors. Some have become friends who have supported my growth and lent me encouragement. My life, not only as a nurse but also as a person, has been enriched by these relationships.

And then there are all the members I've met. These are the nurses in every walk of life, in every form of nursing, in every community in our province. You are the men and women who continue to inspire me. I'm invigorated each and every time I read your stories in this journal, hear you speak at chapter meetings and at the Annual General Meeting, and see the daily summary in RNAO's media clips that catalogues your activities in your communities.

RNAO has also helped me keep up with the rapid pace of change in health care. When I first graduated, the health-care world seemed a simpler place. But today, as knowledge grows daily and evidence-based practice becomes more and more established, RNAO has provided tools and programs that have allowed me to stay current in my chosen area of practice. Belonging to an Interest Group, (or two or three), has also been a crucial part of my growth. Membership in these groups allows me to expand my horizons in areas like nursing research and education. Without access to these resources, I would most certainly be a poorer nurse and a lesser person.

> "My RNAO membership gives me a golden opportunity to make a difference for others, whether they're fellow RNs or the people we serve. I've been part of campaigns for change that have given me a hand in improving health and nursing."

RNAO membership has also brought me peace of mind. I've always opted for the Legal Assistance Program's (LAP) coverage. I didn't really think I would ever 'need' it, but there were times I was glad it was there. I can think of two or three motor vehicle accidents where I was an early responder. Emergency care wasn't – and still isn't – my specialty. In my effort to do what seemed best, there was always a risk that I would err. It was comforting to know that, if I intervened in a prudent way, I had some protection if worse came to worse.

I also never thought I would need LAP when faced with the loss of a job – but I did. The ease of access to counsel and expertise was invaluable. Beyond my own experience, I recall very clearly the colleague who called me one night to share fears that she might be fired. She wasn't an RNAO member then, but she was when it mattered. When she lost her job several months later, she too took advantage of the same high quality advice and counsel that I had relied on in my own time of need.

In addition to everything the association provides for me, my RNAO membership also gives me a golden opportunity to make a difference for others, whether they're fellow RNs or the people we serve. I've learned political action skills and been part of campaigns for change that have given me a hand in improving health and nursing. Sometimes, my actions in this regard have been very public and visible, as they are now. But at other times, depending on circumstances or pressures in my life, I have simply supported the organization's activities through my membership dues. That, too, is one of the strengths of RNAO. Each of us can contribute to positive change in our own way, as fits our needs and capacities at any particular time. That just plain feels good.

So my years as an RNAO member have given me personal growth and encouragement, inspiration, education, protection, advice and counsel, *and* I have been able to be part of making a difference. Still need another reason to renew your own membership or sign up for the first time? Well, my very first nursing professor's words still make a compelling case – join because it is the right thing to do! **RN**

WENDY FUCILE, RN, BScN, MPA, CHE, IS PRESIDENT OF RNAO.

Listening to members, acting on their voices and building a stronger collective

November 1st marks the beginning of another membership year at RNAO. As I look back at everything we've accomplished in the last 12 months, I'm struck by the incredible power of your voices. It's your commitment to speaking out that keeps our association strong, and adds to the conversations that matter most to our profession, our communities and our patients.

One of those discussions was sparked by my last column. My July/August Executive Director's Dispatch triggered four letters from members. Two writers expressed their praise, while others wrote of their disappointment (see page 7), and I value them all. Your opinions and eloquence in voicing them allow our association to move from strength to greater strength. While we may not always agree on each point we debate, it's the openness and intelligence of our discussions that will ensure nursing, health, and health care continue to grow stronger and meet the needs of those we serve.

In the coming year, your voices will be more important than ever as we face the many challenges and opportunities that lay ahead. We must tackle threats to our profession, but that is only one of the battles we must fight to win. Others include: educating the public about the importance of social and environmental determinants of health; persuading politicians to master the political will to act swiftly to eliminate poverty and to clean up our environment; and remaining vigilant in our cause to protect and strengthen our universally accessible health-care system. This last point is extremely important in light of the recent events both in Canada and the United States.

At the annual general meeting of the Canadian Medical Association this summer, physicians passed a resolution calling on governments and health authorities to examine the place internal market mechanisms – including a possible role for the private sector in delivering publicly funded care – could have in our health-care system. The outgoing President of the CMA, Dr. Robert Ouellet, a staunch advocate for more private health-care delivery, said people should not be afraid of the word "competition." In light of this disheartening news, RNAO issued a press release encouraging the new President, Anne Doig, to strengthen Medicare by pursuing not-for-profit solutions – a preference expressed by more than 86 per cent of Canadians in a poll Nanos Research conducted for the Canadian Health Coalition in August.

> "It's the strength of our convictions and force of our voices that will serve us to build a better tomorrow."

Myths about Canada's health system have also been pushed up from the United States, where the wealthiest country in the world still fails to provide health care for all. Opponents of President Barack Obama's plan to provide health insurance for the 45.7 million Americans who currently lack it – including 8 million children – spent the summer dragging out falsehoods about Canada's health-care system. We need to ensure these fictions are not allowed to infect our own discussion on health care. The fact is, our system works.

Americans spend 16 per cent of their GDP on health care, compared to Canada's 10 per cent. Despite the higher cost in the U.S., we in Canada deliver better results. Not only do we provide health coverage to 100 per cent of our residents, we also live longer than our American counterparts (78.4 years vs. 75.4 years for men; and 83 years vs. 80.7 for women). Our infant mortality is also lower at five per thousand compared to 6.7 per thousand in the U.S.

In August, I had the opportunity to speak about the realities and advantages of our health-care system when I addressed the American National Black Nurses Association's annual meeting, which was held in Toronto. It was a chance to share the work we do to protect and extend not-for-profit health care in Canada, and encourage our colleagues to fight for improvements in their own country. The energy in the room was palpable, filled with hope and a desire to make a difference. As the debate continues south of the border, we will continue to offer our support. Our nations' destinies have much in common, and all of our citizens deserve the best.

As nurses, we play a crucial role in bringing about positive social change. After all, it was nurses who mobilized themselves and the public in Canada to help make our Medicare system a reality. Nurses – with the Canadian Nurses Association at the forefront – from coast to coast to coast wrote letters and met with politicians to push for the *Canada Health Act*. Twenty-five years on, nurses, and especially members of RNAO, continue that advocacy role to ensure our health-care system provides care to all who need it, regardless of their income levels.

As we embark on our next membership year, our voices on these issues and many others will continue to be a source of inspiration for us all. Let's work to multiply the number of those voices by encouraging every RN to become an RNAO member and join in speaking out for health, speaking out for nursing. It's the strength of our convictions and force of our voices that will serve us to build a better tomorrow. **RN**

DORIS GRINSPUN, RN, MSN, PhD (CAND), O.ONT, IS EXECUTIVE DIRECTOR OF RNAO.

Mailbag

RNAO wants to hear your comments, opinions, suggestions

Executive Director's Dispatch collects concerns and kudos

Re: Ringing alarm bells on changing models of care delivery, July/August 2009

As a very active member of RNAO, I have a great deal of certainty that the statement "…a demon many of us thought slain 10 years ago: RNs in a few Ontario hospitals being replaced by RPNs and unregulated workers" was meant to introduce the topic of RNAO's work to ensure that patients receive care from the right care provider at the right time in a way that ensures continuity of care. However, the obvious link between the RPNs (and others) we see working with such a level of dedication and skill in nursing teams today and demons cannot be avoided.

The irony that this statement appears in the same issue as an article entitled *Team Building 101* just underscores our need to be extremely careful to ensure that our intent is clear at all times. Building respectful, trusting and collaborative teams is always challenging during times of pressures or change. We all need to advocate for patients while ensuring we do not damage those teams in the process.

Dianne Martin
Executive Director, RPNAO,
Mississauga, Ontario

It is apparent from Doris Grinspun's column that oppressive views of the practical nurse continue to soar. As degree-prepared RNs and professors of nursing, we are saddened to see the lack of recognition for RPNs. Grinspun suggests that RNs work with complex patients and RPNs work with stable patients with predictable outcomes. This language is not supported by the College of Nurses of Ontario. All RNs and RPNs are expected to determine if they have the knowledge, skill and judgment required to provide care clients need. To suggest that RPNs would not be capable of "participating and being accountable for the entire care process, elements which are essential to quality patient outcomes and nurse satisfaction" is to suggest that only RNs are nurses.

When one group of professionals believes it holds all the knowledge and provides the best possible care, oppression emerges. Care from RPNs is no less stellar than care from RNs. Belittling the competencies of RPNs, or ignoring or excluding them from leadership or research positions indicates a serious lack of respect for their knowledge, skill and expertise. Safe, high-quality patient care will only happen when it's recognized that RNs are not the only professionals capable of providing high-quality care. We find it disturbing that Grinspun would choose to continue to facilitate the oppression of RPNs, rather than to use her position to build up nursing. The CNO clearly states that RNs and RPNs are capable of providing high-quality care. To suggest otherwise is inaccurate and unwise.

Sharon Clarke, Bev Trask
and Mary Elizabeth Roth,
Kitchener, Ontario

RNAO's response:

The Executive Director's Dispatch intended to draw attention to the need to safeguard models of care delivery that advance continuity of care and caregiver (for example, primary nursing and total patient care). The column meant to speak up against moving back to versions of "team nursing" that fragment care by assigning RNs, RPNs and Patient Care Attendants to the same patient, with each delivering aspects of his/her care. It clearly states that both RNs and RPNs must deliver and be accountable for the entire care process of their assigned patients, as continuity of care and caregiver are essential to quality patient outcomes and nurse satisfaction. RNAO recommends RNs be assigned the entire care of patients whose condition is unclear, complex and/or unstable, and RPNs be assigned the entire care of patients whose condition is stable.

I enjoyed the Executive Director's column in the July/August *Registered Nurse Journal*. Yes, the erosion of RN jobs continues. How the government will move to reduce alternate level of care (ALC) patients in hospitals and deal with increasing patient acuity while at the same time reducing skill levels is beyond me. It is imperative, now more than ever, to work together to ensure we continue to be patient advocates and uphold quality care.

Linda Haslam-Stroud
President, ONA,
Toronto, Ontario

I enjoyed reading the Executive Director's Dispatch by Doris Grinspun. As a registered nurse, I worked team nursing in the 1970s, and total patient care in the 1980s, and then faced the "new skill mix" workforce in the last decade. It is delightful to see a clear article on the subject.

Audrey Hanson
Barrie, Ontario

Nurse Jackie offers valuable lessons

Re: RNs take on prime time, July/August 2009

After reading many responses to the episodes of Nurse Jackie, I feel there is a great learning from this program. Jackie is a hard working nurse. However, she also faces many stressors on a daily basis. What can be done so nurses can learn from Jackie? What resources are available for nurses like Jackie? Should nurses be more educated about burnout before entering the profession and given resources to take care of themselves? Should nursing schools and health-care organizations offer problem-solving scenarios based on the challenges Jackie faces?

This program can be used to better support nurses to ensure they also take care of themselves.

Sutra Parmasad,
Toronto, Ontario

Personal story ignites pride

Re: Reflections on Nursing, July/August 2009

Thank you for selecting my story *Strength Inside Sorrow* for publication. I was thrilled to have it included in the wonderful accounts of so many brave and inspiring RNs. We represent diversity, complexity and ingenuity and use our skills in such a wide variety of clinical settings.

Joanne Jones,
Whitby, Ontario

by Stacey Hale

Nursing in the news

RNAO & RNs weigh in on . . .

Cancer's youngest victims

Children and families who have been affected by cancer had a chance to talk about the disease during Childhood Cancer Awareness Month in September. RNAO member **Margaret Warden** was featured in *The Londoner* (Sept. 8) for her work as one of the 10 pediatric community cancer nurses in Ontario. For 20 years, Warden has worked with children coping with cancer. She has spent the last five years as a Pediatric Interlink Community Cancer Nurse. She helps guide families through treatment and recovery and separates myths from facts about the disease. "There is so much involved when your child is diagnosed with cancer… My job is to talk about diagnosis, prognosis, treatment, drugs and do an assessment of the whole family," she said. Meanwhile, in Waterloo, **Patti Bambury** helps cancer patients get treatment in their own backyard. Bambury is an out-patient resource nurse and clinic coordinator at the local Pediatric Oncology Group of Ontario satellite clinic. Her youngest patients can receive chemotherapy while living lives that are as normal as possible. "Kids are able to come here in the morning and get their treatment and go to school in the afternoon. We have kids in-between treatments still playing hockey or baseball if they're well enough," Bambury said (*Waterloo Chronicle*, Sept. 9). **RN**

RN Margaret Warden (right) told the *Londoner* about the work she does to help kids who have cancer, including 13-year-old Jessie Norbury (left).

Photo: courtesy Sean Meyer, *The Londoner*

Unregulated health professionals

In August, RNAO Executive Director **Doris Grinspun** called the provincial government's plans to launch physician assistants (PAs) as a new health profession "risky and expensive." Beginning next January, a new batch of PAs will start their training at the University of Toronto. After just two years, they'll be qualified to treat patients in doctor's offices, hospital emergency departments and surgery suites across the province.

PAs work under the supervision of physicians and are being deployed across Ontario as part of a pilot project run by the Ministry of Health. But Grinspun warned patient safety is at risk since PAs have limited education (when compared to other health professionals) and are not regulated. "We absolutely oppose this," she told the *Toronto Star* (Aug. 18), adding that introducing PAs is more expensive than simply employing more nurses and nurse practitioners.

Job swapping rejected

In September, RNAO member **Donna Bain** helped close a loophole that was allowing hospitals to transfer nurses from one job to another to cut costs. A provincial arbitrator ruled that reassigning nurses whose jobs have been declared surplus constitutes a layoff. That means they get the same rights under the collective agreement as nurses losing their jobs. "I had no doubt that's what the decision was going to be," says Bain, President of the Ontario Nurses' Association Local 75 at St. Joseph's Healthcare, told the *Hamilton Spectator* (Sept. 8). "This was just the employer's last-ditch effort to find a loophole." The decision, which involved St. Joseph's and Hamilton Health Sciences, is a challenge for hospitals that were hoping to have the

For complete versions of any of these stories, contact staceyh@rnao.org.

flexibility to cut positions while keeping staff on hand to fill other vacancies.

Changing models of care delivery

Following media reports that a patient at Kingston General Hospital (KGH) allegedly contracted a hospital-acquired infection, suffered undiagnosed heart attacks and was neglected by nursing staff, RNAO expressed concern for patient care at the hospital as it attempts to balance its roughly $30 million budget shortfall. RNAO President **Wendy Fucile** wrote a letter to the *Kingston Whig-Standard* expressing sadness for the patient's experience. "This is not the kind of situation any nurse feels satisfied with," she wrote (Aug. 6). In a similar story that same day, RNAO Executive Director **Doris Grinspun** told the paper nurses and patients should not be "pawns in this race to balance budgets." The articles were printed the day before Grinspun and RNAO staff members met with senior hospital administrators and nursing staff at KGH to discuss new models of patient care. During the meeting, which the *Whig-Standard* covered on Aug. 7, the hospital clarified that RPNs will look after stable patients for their entire visit, while RNs will care for complex patients. RNAO member and KGH chief nursing executive **Eleanor Rivoire** told the paper the hospital wanted to ensure staff fully understood any changes.

Preparing for a flu outbreak

For months, RNs have been working with hospitals and government to get ready in case a possible surge of H1N1cases overwhelms the health-care system. RNAO member and North York General Hospital RN **Carolyn Edgar** said nurses feel more prepared than ever before. "There has been a concentrated effort on mask-fit testing and on personal protective equipment. If you go back to SARS, we didn't have this," she told the *Canadian Press* (Sept. 3). In Richmond Hill, **Tiziana Rivera,** acting chief practice officer at York Central Hospital, says the hospital's pandemic committee has been meeting weekly since the beginning of the outbreak. "Our goal is to ready the hospital should there be an influx of people that need assistance," she told the *Richmond Hill Liberal* (Aug 6).

Schools are also planning for potential outbreaks. RNAO member **Elyse Maindonald** works in the campus health clinic at the University of Windsor and St. Clair College and said people need to know about H1N1. "People have to be educated. They have to believe there's a problem, know what it is, and how to handle it," (*Windsor Star*, Aug. 8).

Diabetes care

In August, RNAO member **Debbie Hollahan** helped Nick Jonas, a member of the Jonas Brothers music group, launch his juvenile diabetes education program in

Jenna Dick, 15, signs a poster of Nick Jonas. Dick attended a diabetes awareness event hosted by RNAO member Debbie Hollahan.

Photo: Ernest Doroszuk, *Sun Media*

Toronto. Just hours before he performed at a concert, Hollahan, a diabetes nurse educator at Credit Valley Hospital, hosted an event to introduce the Simple Wins program in Canada. Jonas, who has type 1 diabetes, has partnered with a pharmaceutical company on the program, which offers teens a glucose metre and web-based

In August, the Canadian Medical Association (CMA) held its annual meeting in Saskatoon and debated changes it believes are needed to improve Canada's health-care system. On Aug. 21, RNAO President Wendy Fucile wrote a letter to the National Post expressing her concern that the CMA's proposed prescription for change would be focused on privatization.

Competition and medicine don't mix

Re: Doctors Push for Competition, Aug. 19.

Nurses are disappointed that the Canadian Medical Association (CMA) has chosen to continue pushing its privatization schemes, despite solid evidence that they are dangerous for the public. Schemes that promote competition among health-care institutions run the risk of pitting doctors against one another in a bid to lure healthier patients. The marketplace has no business in the delivery of health care and patients should not be regarded as commodities. Access to health care is a human right, not a privilege for those who can afford it. It is sad the CMA is ignoring 86 per cent of Canadians recently polled who support not-for-profit solutions to strengthen the country's public health-care system. The CMA's new president, Dr. Anne Doig, should also listen carefully to those whom she represents. In a 2005 survey, only 27 per cent of physicians said they favoured a purely private health-care system.

Wendy Fucile,
President, Registered Nurses' Association of Ontario, Toronto

Nursing in the news

RNAO & RNs weigh in on . . .

information about the disease. "One of the biggest challenges with kids, especially teenagers, is that they want to keep their diabetes a secret and they don't want to be different," Hollahan said. "For Jonas to come out and say he has diabetes is very inspirational and encouraging," (*Mississauga News*, Aug 25).

Tackling youth obesity

In August, RNAO member and nurse practitioner **Beth Van Dusen** and residents of Campbellford attempted to create the longest trail of toonies in Ontario. The community hoped to raise additional funds to build a skateboarding park to keep area kids active and reduce rates of adolescent obesity. Van Dusen said the park will provide children with a clean, safe place to exercise and have fun (*Stirling and Campbellford Expanded Market Coverage*, July 31).

Beth Van Dusen (centre) helped raise $940 in toonies to build a new skatepark for local kids.

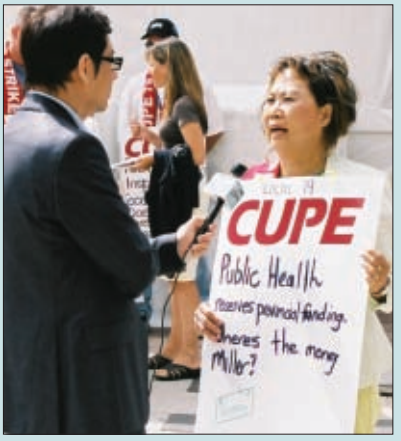
Injury prevention

In August, the Waterloo Public Health department put a price tag on the cost of injuries in the region. The health department partnered with injury-prevention group Smartrisk to prepare a report that found that, in 2004, broken bones, bumps on the head, whiplash, and other mishaps cost the city $294 million.

Last year, RNAO member **Jane Foster** calculated that a minor car crash — from patients' arrivals at the hospital through to their assessment, treatment and then release — cost $511.80. She says proper education, deterrence and precautions could significantly cut the costs associated with the largely preventable conditions. "When you talk about doctors' time, nurses' time, sewing up cuts, the cost of X-rays ... even for a minor injury (the cost) is mind-boggling," (*Waterloo Region Record* (Aug. 19). **RN**

Out & About

In September, RNAO board member Nancy Purdy (far right) lent the association's support to Sault Ste. Marie MPP David Orazietti's (second from right) proposed Breast Screening Act. If passed, the bill would increase access to the Ontario Breast Screening Program for women aged 40-49. Joining Purdy at the press conference to announce the new legislation were Naomi Rose, Canadian Breast Cancer Foundation, (left) and Martin Yaffe, senior scientist from Sunnybrook Health Sciences Centre.



Toronto public health nurses were among those on the picket lines during the city's civic workers strike this summer. RNAO member Betty Wu-Lawrence (right) spoke to reporters at a rally RNs organized to raise awareness of the work they do, including infection control, working with high-risk mothers, operating the healthy babies program and running sexual health clinics.

Photo: Courtesy Daniel Boyer

RNAO Past President Joan Lesmond was a keynote speaker at the National Black Nurses Association conference in August. The American group held the meeting in Toronto, and Lesmond and RNAO Executive Director Doris Grinspun were among the guests. Lesmond's speech focused on her work and the diversity in the profession.

Toxic smoke looms in the O.R.

RN uses expertise in laser safety to combat airborne vapours that have health effects as harmful as cigarette smoke. BY STACEY HALE

When Susan Taylor enters the operating room to prepare for surgery, she is well aware that live viruses, bacteria and toxic vapours are still floating in the air after the previous procedure, and they threaten to catch in the eyes and throat of anyone inside the O.R.

When human tissue is cut or coagulated with surgical lasers, bone saws, electrocautery and other tissue-burning tools, it releases airborne particles called "plume." Although the long-term effects of plume have only recently begun to be studied, Taylor says it can cause vomiting, dizziness, fatigue, and liver and kidney damage. In fact, some studies have shown inhaling one gram of laser-cut tissue is like smoking three unfiltered cigarettes.

"I think for a lot of years, people have been very complacent about plume," says Taylor, a Nurse Educator and Laser Safety Officer at St. Joseph's Health Care in London.

That's starting to change. Within the last two decades, Taylor says people have started to take toxic air more seriously. Researchers have identified more than 600 organic compounds and a host of chemicals in plume, including cancer cells, blood fragments, bacteria spores, HIV and human papillomavirus DNA, as well as carbon monoxide and formaldehyde.

Taylor has been the laser safety officer at St. Joseph's for almost 10 years, and in 2004, she began working in the role at other hospitals in London. She splits her time between different hospitals teaching nurses, physicians, residents and other O.R. staff how to set up a laser, tear it down and about the safe practices that need to be used around the tool, including using the large vacuum-like plume evacuators. Equipped with a pump, filter, hose and a nozzle, the machines can suck up the smoke before it's inhaled.

Taylor has worked in the operating room for 33 years and says she loves her work because there's always something new to learn. "You can be in one operating room for a week and never hit the same case twice," she explains.

NAME: Susan Taylor
OCCUPATION: Nurse Educator and Laser Safety Officer
HOME TOWN: London, Ontario

After graduating from the Perth-Huron Regional School of Nursing in Stratford, Taylor worked in psychiatry and then spent two years in an oral surgeon's office. She also went to the United States to become certified as a medical laser safety officer through the Laser Institute of America.

Throughout her career, she has seen first-hand how plume affects nurses. Before St. Joseph's started using mobile plume evacuators four years ago, her colleagues would complain of headaches, eye irritation and nausea.

"Physicians are in the operating room maybe one day a week, sometimes two. It's the nurse who is in the operating room five days a week, eight hours a day," she says.

Taylor remembers one nurse in particular who approached her after one of her safety classes. The woman explained she used to work in a small community hospital that didn't use plume evacuators. For three of the five years the nurse spent there, she'd frequently been sick with pneumonia. The woman's physician kept asking her if she was a smoker, but she wasn't. When she started working at a hospital that uses plume evacuators, she stopped getting sick and realized her illness may have been caused by her work.

Taylor knew this story was just the tip of the iceberg. "I started thinking, people need (laser safety) information," she says, especially considering the number of surgical procedures using lasers and electrocautery is on the rise. "It's important that we try and protect our health."

So when Taylor was approached two years ago by the Canadian Standards Association (CSA) and asked to help develop national guidelines for capturing and disposing surgical plume, she couldn't refuse. She joined a committee of more than a dozen experts, including engineers, respiratory experts, representatives from industry, and clinical experts, which met via web conference to decide what needed to be included in the standards. The guideline was written and published in 18 months.

"It was one of the most cohesive groups I have ever worked with," Taylor says. "Everybody felt that this needed to be put in place." The standards, which offer advice on protection from the laser beam and plume, were officially released in March. For now, adopting the CSA guidelines is voluntary, but Taylor says any accredited health-care institution in Canada must follow them if they want to remain in good standing. Taylor says that's great news, because her favourite part of her job is empowering nurses to keep themselves, and their patients, safe.

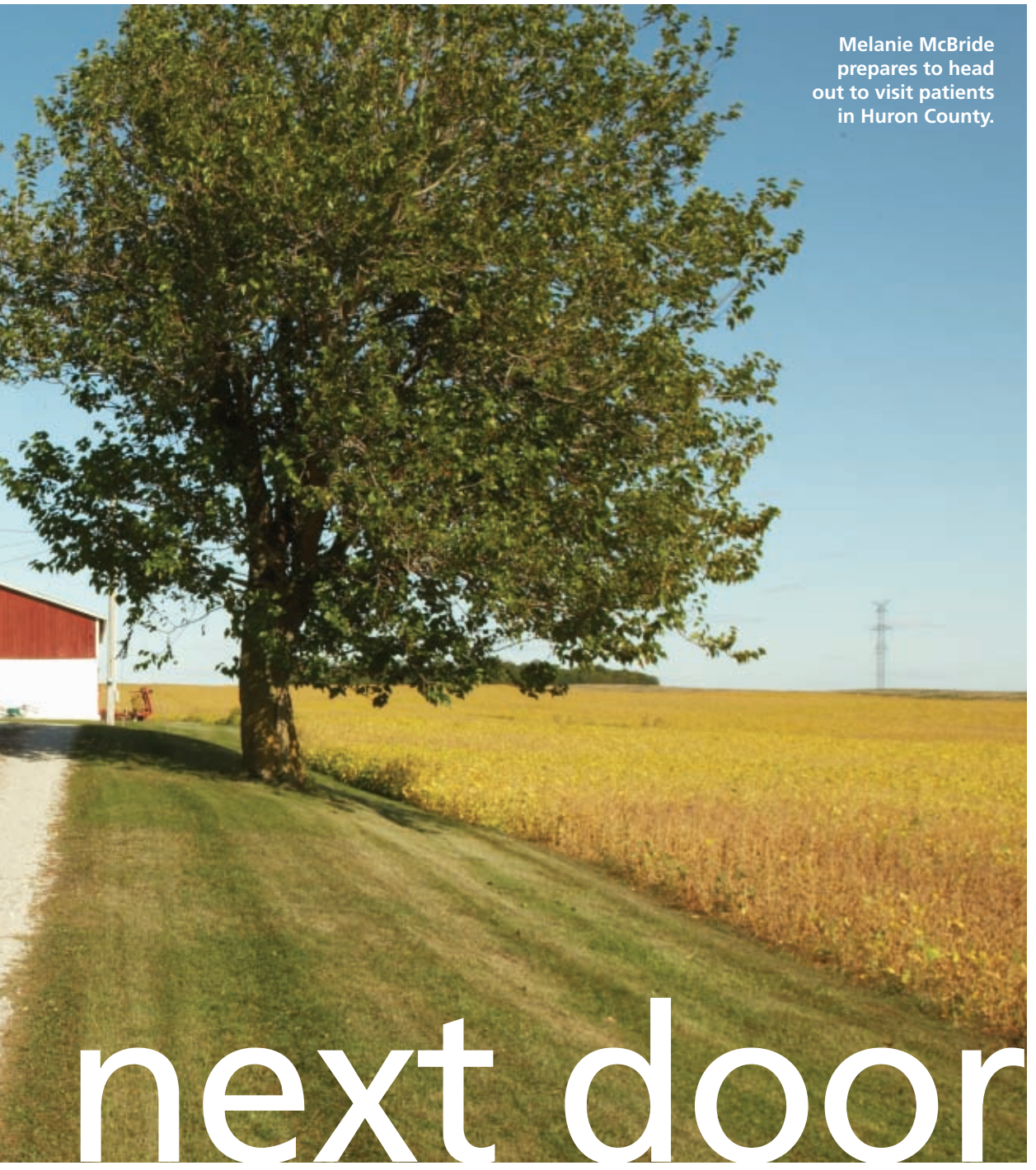
"I think it's time that we did something to ensure that we are protecting the nurses that we have," she says. RN

STACEY HALE IS EDITORIAL ASSISTANT AT RNAO.

the nurse

RNs in small towns have the chance to care for their neighbours. The challenge is finding more people to work in rural communities.

BY JILL-MARIE BURKE • PHOTOGRAPHY BY LAURA ARSIE



Melanie McBride prepares to head out to visit patients in Huron County.

next door

As she pulls her SUV out of her driveway, RN Melanie McBride makes a mental inventory of the supplies stored in the plastic drawers in the back. Gauze? Check. Wound dressing and packing supplies? Yes. Equipment to insert IVs and draw blood? Absolutely. Diapers? Just in case. McBride never knows what might be needed in a pinch when she checks in on her patients who may be on dialysis, undergoing chemotherapy or in need of wound care.

McBride works for Saint Elizabeth Health Care and her clients live along the rural roads and in the small communities on the shores of Lake Huron. As she heads down County Road 2 past fields of corn and soybeans, she thinks about the man who would have become a palliative care patient if she hadn't realized that complications following abdominal surgery were killing him. His incision wouldn't stop draining, he had a fistula, and he had lost a lot of

weight. McBride pushed the surgeon to see the man again, and during a second surgery the physician found an undissolved stitch that was causing the problems. Today, at 81, the man is healthy and getting ready for another winter at the curling rink.

McBride grew up in Huron County, but she hasn't always been a rural nurse. She worked on a neurological floor at a London hospital for four years, but decided to explore other options when she started feeling burned out. She joined Saint Elizabeth three years ago and says the job gives her a chance to give back to people in her own backyard and broaden her nursing knowledge along the way.

"I find it very rewarding," she says. "I still learn something new every week."

McBride is among the four per cent of Ontario nurses who the Canadian Institute for Health Information reports work in rural settings. Their patients are neighbours and friends they're likely to run into at the supermarket on a Saturday morning, and some of them say they would never trade their work for a big-city job. According to the Ministry of Health and Long-Term Care, more than 4.8 million rural Ontarians depend on the expertise of nurses like McBride to keep them healthy, but recruiting and retaining RNs with the specialized skills needed is an ongoing challenge for health-care organizations. According to a 2006 study by the Nursing Health Services Research Unit, almost 42 per cent of nurses in the South West Local Health Integration Network (LHIN), where McBride works, are over the age of 50.

"We're not going to attract and retain nurses if we don't give them the theoretical and clinical experience in rural areas they'll need."

The provincial government has started to address the looming shadow numbers like that cast on the workforce. In 2006, after strong advocacy by RNAO, it began reimbursing tuition for new graduates from rural areas who return to their communities to work. And this summer, the government announced a new Rural and Northern Health Care Panel, including several RNs, that will look at ways to improve access to health care. Nurses and researchers who study health-care beyond the province's urban centres say tapping into the expertise in Ontario's hinterland is essential. Simply transplanting recruitment and retention strategies that have worked in larger cities isn't the answer. Nurses in small towns see everyone from seniors to pediatric patients all in one shift. They never know when they'll need to respond to a car accident, farming mishap or flu outbreak, or provide care to isolated families that might be coping with poverty or abuse.

Beverly Leipert is a professor at the Arthur Labatt Family School of Nursing at the University of Western Ontario. She

NURSING STATIONS SHOULD HEAD SOUTH

Remote nursing stations have been part of the Canadian health-care system since the 1920s, and have traditionally only been used in the far north. But they could be used in rural areas of southern Ontario to provide care. According to the Ministry of Health and Long-Term Care, 34 communities in northern Ontario are designated as 'under serviced,' and 21 of them have nursing stations. But southern Ontario has an alarming 100 'under serviced' communities, none of which has adopted the nursing station model.

Nursing stations managed by nurse practitioners (NPs) are a variation of NP-led clinics, but they are more suited to rural communities, which typically lack human resources. Nursing stations are affiliated with a supporting hospital. For example, the West Parry Sound Health Centre (WPSHC) operates six nursing stations, each managed by a nurse practitioner. Last year, the stations saw more than 25,000 patients, equal to the number seen in the hospital's emergency department.

At the WPSHC-operated Rosseau Nursing Station where I work, many of my patients are seniors, teenagers and summer cottagers. I perform a full range of duties including lab services, house calls, and emergency treatments. I also provide preventive health education, treat chronic and episodic illnesses and injuries, and collaborate with physicians when needed. Those who live in the area year-round often have a physician in Parry Sound; however, wait times are four to eight weeks for an appointment. The nursing station plays a critical role in providing people with access to primary care. More than 90 per cent of my patients' care is completely managed at the nursing station.

The WPSHC is part of a research project designed to capture the full impact the nursing stations have on their communities, and on the hospital and local health-care resources. Preliminary findings show

The Rosseau Nursing Station near Parry Sound, Ontario.

the stations save the hospital money. Only three to five per cent of patients seen in the nursing stations are referred to the emergency room, there are fewer hospital admissions from rural communities than from larger towns, and re-admission rates are significantly reduced. Just 33 per cent of patients from rural communities return to the hospital within one month, compared to 58 per cent of patients from Parry Sound.

The time is right to take a closer look at using this model throughout rural Ontario, using the most appropriate health-care provider, in the most appropriate place, to provide health care without geographic, age, or economic prejudices. Could nursing stations be coming to a town near you? Let's hope so. RN

Donna Kearney has been the primary health care nurse practitioner at the Rosseau and Area Nursing Station near Parry Sound since 2003.

studies rural women's health and spent part of her career as a public health nurse in the prairie towns of Saskatchewan. Leipert says nurses are much-needed in rural areas, especially if they visit patients at home. If a woman is isolated, a nurse could be the only person to notice if she's burning out from the multiple roles of raising children, working on the farm, holding down a paid job in town and volunteering in the community, or if a crop failure has left a family living in poverty and under stress.

"A visiting nurse might initially think a new mom probably has lots of questions about breastfeeding, but then find out there's no food in the fridge," she says.

Leipert believes if more urban RNs are going to think about caring for people who live in the villages and on the farms of Ontario, they need to learn about the demands – and rewards – of the job while they're in school. Leipert has developed two courses in rural nursing at UWO; one for undergraduates and one for masters and PhD students. The graduate course features a field trip into rural communities where students can talk with nurses, nurse practitioners, social workers and other members of health-care teams.

"We're not going to attract and retain (nurses) if we don't give them the theoretical and clinical experience in rural areas they'll need," she says.

In 2007, Grey Bruce Health Services (GBHS) Vice-President of Clinical Services Sue McCutcheon knew she was going to have to get more nursing grads working in her hospitals on the shores of Georgian Bay, or patient care would suffer. More than 40 per cent of the hospitals' RNs were going to be eligible for retirement within five years. In fact, the small obstectrics program at GBHS's Markdale location closed after two very experienced RNs retired. McCutcheon says it was difficult to find nurses to replace them because they need more than labour and delivery skills. Nurses also have to be able to work in the medical/surgical unit and emergency department when obstetrics isn't busy. Meanwhile, Georgian College no longer offers a nursing program in Owen Sound, so students who grew up in the area don't complete placements at GBHS as part of their degree program.

The hospital's tailor-made solution was to create opportunities for nursing students and new grads. For the past three summers, a small number of nursing students have worked at GBHS as student aides, and the first students to participate in the program were recently hired upon graduation. When students from the area graduate, they're also invited to come home and learn about nursing in their own community by participating in a one-year mentorship program.

"We encouraged new graduates who had done their education anywhere in Ontario or Canada to come home and we would facilitate some of their clinical education here in our organization," says McCutcheon. "This would provide the groundwork for them to become independent practitioners in a well-supported way."

The goal of the mentorship program was to help the new nurses develop competence and confidence in everything from patient care and building relationships with physicians to understanding how the health-care system works.

"If you work in a rural hospital and you need to transfer a very sick patient to an urban centre, you need to know a lot about the system to be able to advocate for that patient and get him appropriately transferred in a timely manner. It's not just about making sure you get an IV in really quickly, it's about really navigating the system for patients," says McCutcheon, adding the program is paying off. In the past two years, GBHS has hired 19 new grads and most are still working there today.

While McCutcheon was dealing with retirements, Katherine Stansfield, Vice-President of Patient Services and Chief Nursing Executive at Quinte Health Care in Belleville, had another problem on her hands. Nurses working on medical floors who didn't have the skills or experience needed to care for the wide variety of patients they encountered were transferring to other departments as fast as they could, leaving the medical floors short-staffed by 30 per cent. Stansfield knew the root of the problem was the fact that the new hires (whether they were recent graduates or experienced RNs) had worked in urban, tertiary care settings that exposed them to just one sub-section of a population or one specialty. But at Quinte Health Care, stroke and cardiac patients and individuals with other complex conditions are all located on the same medical floors, and nurses are responsible for meeting all their needs during each shift.

REVIVING A RURAL CHAPTER

Leslie Secord says that on days when a nurse working in a small hospital or community feels like a tadpole swimming in a really large lake, RNAO is a reminder that you're not alone. That's why Secord decided to take on a leadership role when three of RNAO's chapters were on the verge of collapse.

While the number of members in the Parry Sound, Muskoka and Huronia chapters was steady at around 400, Secord says RNs were starting to wonder why their chapters weren't doing more. Although she'd been a member of the Muskoka chapter throughout her career, she had never held an executive position and rarely attended meetings. But she worried that if she didn't step forward to revitalize the chapters, they would fizzle out.

Last summer, nurses in the region decided to amalgamate the three chapters on a trial basis and Secord, an RN at South Muskoka Memorial Hospital (SMMH) in Bracebridge, became the president and now works with a full executive and a workplace liaison at SMMH. The new chapter held its first meeting in Bracebridge in the spring, and six people attended. Secord says that's a good start because the nurses were enthusiastic, and getting people to come to meetings is an accomplishment in a region where distance and weather are frequent travel obstacles.

"The roads are treacherous at the best of times," says Secord. "In the summer you're dealing with lots of traffic, and in the winter you're dealing with snow. After a 12-hour shift, the last thing members might want to do is pack up and drive an hour to Parry Sound for a meeting."

Secord is hoping that technology will help the newly blended chapter regain its spirit. She'd like to use video conferencing for future meetings. If that's not possible, she says she'll try teleconferences or videotaping meetings and making DVDs available to local RNs.

In the meantime, she has set up a chapter Facebook page to engage current members and attract new ones. It's all part of the group's efforts to make sure all RNs get the most out of their memberships, whether they're looking for legal assistance or best practice guidelines. RN

With funding from the Ministry of Health and Long Term Care's Nursing Secretariat, Quinte Health Care worked with Loyalist College to create a rural practice internship for new hires in the medical units. Last year, nurses took classes at Loyalist and worked in the school's simulation lab to practise caring for a range of patients in a wide variety of complex clinical settings. The curriculum also addressed a situation that is common in rural communities – how to maintain professionalism when the patient is your friend, co-worker, neighbour or family member. Back in the hospital, the RNs were mentored by an experienced nurse who coached them through the first month on the job.

Stansfield says the program has paid off. The medical units are no longer short-staffed, and new hires are staying on – even when positions on other units are advertised.

"The evaluations from the new employees were overwhelmingly positive," says Stansfield. "They really felt there was an emphasis on investing in them to be successful."

Last year, Stansfield teamed up with nurse researchers who are looking at the staffing challenges small hospitals face when she became part of a two-year study on retaining rural nurses. Jennifer Medves, one of the lead investigators and the Director of Nursing at Queen's University, says researchers are asking staff RNs at a number of rural hospitals about the difficulties their organizations have finding staff – and what needs to be done to get RNs interested in small-town nursing practice.

Medves says because much of the research on recruitment and retention refers to urban hospitals that employ large numbers of nurses, rural health-care organizations often need to develop homegrown initiatives like the internship at Quinte Health Care.

"If you've got a cadre of nursing staff of 300 and you lose one or two a month, it's not such a big issue to go out and recruit more. But if you only have 20 staff members and you lose one, that has a much bigger effect on your ability to provide care. Of course, recruitment and retention is very important everywhere, but in rural places it's really more critical because you want to keep staff who are able to work in an environment where they become 'multi-specialists,'" says Medves. She says rural nurses' skills range from coping with multiple injuries from a car accident and getting victims evacuated to a tertiary care centre, to working in non-traditional teams that often don't include specialized emergency room physicians, respiratory technicians or other health-care professionals found in urban hospitals. Still, despite the challenges, Medves says she's constantly impressed by the dedication these RNs bring to their work.

"They feel really bad when they're sick because they know that their colleagues are putting in extra time," she says. "And nurses' families get used to the fact that mom or dad occasionally gets up from the supper table to go back to work if they're called in. There is a tremendous loyalty to their organizations and their communities and collegiality with their colleagues. It's very heartening."

Nancy Rozendal's career is founded on that kind of loyalty. She's nursed in rural hospitals for 32 years, the past 19 on a medical/surgical floor at Listowel Memorial Hospital. Born and raised near Listowel, she knows almost everyone in town and can't think of anywhere else she'd rather live or work. But she understands why it's hard for her hospital to recruit nurses who don't have a connection to the town. "For a young person who wants to go out on Friday and Saturday nights, there's not a whole lot here to offer them. The younger nurses we do have are generally from our area, have families and don't want to be out of town when their kids are at school," she says.

Rozendal isn't surprised Medves' research shows rural nurses need to be specialists in just about every kind of care. On her floor there are two intensive care beds, four telemetry units and some pediatric patients. It isn't unusual for her to be monitoring five patients on a night when there's no doctor in the building. He's home sleeping, but can be called if there's an emergency.

Rozendal is a member of *The Nursing Shortage and You*, a grassroots group of nurses who want the public to understand the impact the nursing shortage has on RNs and patient care. She says the challenge of recruiting nurses to work in a community of 6,500 people affects her work every day. For a number of years, she was the only part-time nurse on her floor and often took on extra shifts so full-time staff could take their holidays. She remembers a Saturday night a few years ago when she was charge nurse and a colleague called in sick at 8 p.m. Rozendal couldn't find anyone to replace the nurse, so she worked a double shift. While there are a few more staff members on her floor these days, it can become short-staffed if a nurse needs to accompany a patient who is being transferred to another hospital by ambulance.

Rozendal says knowing most of her patients personally makes her care even more. That's why she worries about the day that staffing and workload issues will make it impossible for her to juggle the competing needs of all her patients. "I've worked there for 19 years and have the reputation for being a good nurse who is there when people need me. But as soon as I can't be there for those people, the public will perceive that I don't care. They won't see that I'm too busy."

For now, Rozendal is available whenever her patients need her – whether they call her at home to ask her a question, or stop her in the supermarket to give her an update on the medical test their mother just had. She says her biggest reward is being there to care for people she's known her whole life as they near the end of their's. "I've stood at the bedside and cried with families," says Rozendal. "They're not my family members, but I love them because of the associations I've had all through my lifetime with these people." RN

JILL-MARIE BURKE IS ACTING STAFF WRITER AT RNAO.

NURSE EXPERTS APPOINTED TO RURAL AND NORTHERN HEALTH CARE PANEL

Four RNAO members are part of a provincial government-appointed panel that will identify ways to improve access to health care in rural and northern communities.

LYNN BROWN, a nurse practitioner with the Victorian Order of Nurses in Fort Erie, Ontario.

MARGRET COMACK, chief executive officer at the Listowel Wingham Hospitals Alliance in North Perth, Ontario.

KATHY FARIES, a nurse practitioner in Moose Factory who works for the North Shore Tribal Council in Northern Ontario.

DONNA WILLIAMS, a Telemedicine Program Manager with Keewaytinook Okimakanak Telemedicine in Balmertown, Ontario. RN

Wound care wanted

New interest group aims to make specialized support available to everyone who needs it. BY STACEY HALE

Ann-Marie McLaren keeps a special quarter in her pocket to remind herself that you can't always win life's battles, but you've still got to try. The 25-cent piece bears a picture of Terry Fox during the incredible cross-Canada run he began with an artificial leg almost three decades ago.

The coin is a gift from a patient who lost her lower leg after a long battle with an infected foot wound that began as a complication of diabetes. The woman, who was in her 60s, wanted to reassure McLaren that she is healthy, active and happy with her new prosthesis.

McLaren was devastated the day the woman decided to have the amputation. But she could understand her patient's reasons. The problem is a question of access. For many Ontarians, specialized wound treatment close to home just isn't available. McLaren's patient spent five years making trips from her home in Owen Sound to get treatment at St. Michael's Hospital in Toronto.

"Her whole life was consumed by the wound… dressing changes, antibiotics, controlling her diabetes," McLaren recalls. "She couldn't walk, so she decided that she'd had enough."

Far too often, McLaren, a chiropodist, and her colleague Laura Teague, a nurse practitioner (NP), see the serious effects wounds have on people. The two women work together on a high-risk wound care team at St. Michael's Hospital, and spend their days assessing and treating pressure ulcers, venous leg ulcers, diabetic foot ulcers and other complex wounds. Sometimes they have to help people make tough decisions when a wound has become so infected that patients must lose an arm or leg to stay alive. Although Teague and McLaren love their jobs, they admit the work can be frustrating because they want to prevent these situations in the first place.

"A wound can end your life. People can die from an infection," says Teague.

Teague knows she'll need more than one voice to get wound care on the political agenda. Last year, she asked some of her long-time colleagues if they'd be willing to take on an advocacy role. Then Teague approached RNAO with her plan: form an interest group that will push caring for wounds to the forefront of health policy.

RNAO member Laura Teague, left, and chiropodist Ann-Marie McLaren assess a patient suffering from heel ulcers. The two are part of a specialized wound care team.

Photo: Courtesy St. Michael's Hospital

Last fall, the Ontario Woundcare Interest Group (OntWIG) was officially born. Teague wanted to make OntWIG an affiliated interest group (which can include RNs and other health professionals, as long as most group members belong to RNAO) because then it could be open to other wound experts.

"Wound management requires more than a single discipline," Teague explains.

The group's ultimate goal is to improve access to treatment in Ontario. In fact, even before OntWIG officially formed, Teague and other executive members spearheaded RNAO's annual wound care conference and contributed to the development of RNAO's best practice guidelines (BPGs) on pressure ulcers, venous leg ulcers and diabetic foot care.

When OntWIG's members meet this November, Teague, who's now the group's president, says they'll look at ways they can increase awareness among their colleagues about the best ways to prevent and treat wounds. They'll also talk about strategies to lobby funding bodies to study the problem, and make sure everyone who needs high-quality, specialized care can get it from professionals who have access to resources like RNAO's BPGs. McLaren says there are lots of people like her former patient who drive hours for care. And that's a problem that shouldn't be allowed to exist.

"Why is that level of care not available to every person in Ontario, close to their homes?" she wonders.

Teague believes that if the government doesn't step up with support to rub out wounds, there are only going to be more people like the woman from Owen Sound. She says increased chronic disease rates and the number of people living with the complications of illnesses such as diabetes mean OntWIG's work is important now to avoid the potentially damaging wound issues that could come along with the disease. A lack of specialty care also has implications far beyond patients and their families. Teague says patients suffering from chronic wounds spend more time in the hospital and take longer to heal.

"Wound issues are not only crippling patients, but the entire health-care system," she says. **RN**

STACEY HALE IS EDITORIAL ASSISTANT AT RNAO.

All a twitter

Social media tools and technology are reshaping the way nurses share information.

By Jill-Marie Burke

On a Friday morning in June, 'nursekama' is hanging out at a coffee shop surfing the Internet on her laptop while she enjoys an earl grey tea with soymilk and a shot of vanilla. Suddenly, her Google Reader – a tool that scans websites for the newest content – alerts her to a statistic she is anxious to share with the mental health providers, nursing colleagues and real-life friends who make up her online community. Setting down her mug, she quickly taps out a message on her keyboard: *3,616.....The no. of Canadians that have been hospitalized for suicide attempts since May 1, '09* and sends it into cyberspace with a link to mindyourmind.ca, the website where the news originated.

'Nursekama' is using Twitter, a social-networking website that allows users to post 140-character messages called 'tweets.' 'Followers' read the messages to stay updated on the daily activities or topics members of their network are interested in.

'Nursekama,' or Kamini Kalia as she's known in real life, is a clinical nurse specialist who works in the Psychosis Program at St. Joseph's Regional Mental Health Care in London and St. Thomas. Last year, she discovered that using Twitter was an effective way to spread the word about the three nursing topics Kalia says she is most passionate about: mental health and psychiatry; interprofessional education; and collaborative practice. She uses Twitter to find out what experts are saying, share research findings, promote conferences, websites and documentaries and to stay in touch with health-care professionals in Canada and other countries.

"Twitter is also an opportunity for me to further my advocacy work," explains Kalia. "Stigma is one of the greatest issues that we want to overcome in mental health. Since it's a social issue, I thought that social media could be used to counteract it. Through Twitter, I can support people in their own anti-stigma initiatives, express my own thoughts or share the experiences of those who live with mental illness."

Illustration: José Ortega

Social media is quickly becoming an integral way for RNs to share information, promote the profession and encourage political action. In the past year, RNAO has started tweeting about Medicare, posted items on the best practice guidelines and action alerts on the association's Facebook fan page and uploaded videos such as one on the announcement of nurse practitioner-led clinics to the video-sharing website, YouTube. And thanks to the work of Nursing Students of Ontario members, RNAO now has its own page on Wikipedia, an online encyclopedia that anyone can contribute to.

RNAO is also developing social networking tools of its own. The International Affairs and Best Practice Guidelines (IABPG) Program recently introduced the NURSE (Nurses Using Research to Sustain Excellence) Guideline Network, a free site that provides resources for implementing the BPGs and allows users to share expertise related to various guidelines. And an online RNAO community is currently being developed so members who live in the same regions of the province or who work in similar practice areas can talk about the RNAO initiatives they're most interested in.

"There is a vast potential for tapping into the technologies to transfer knowledge, share stories, advocate for health, educate patients and network."

RN Robert Fraser says it's exciting to see more and more RNs using these tools because they make it possible to get the latest knowledge and information quickly.

"There is vast potential for tapping into the technologies to transfer knowledge, share stories, advocate for health, educate patients and network," he says.

When Fraser was an undergraduate nursing student working on a project at Southlake Regional Health Centre in Newmarket, he asked his Twitter followers what types of policies their health-care organizations had on nasogastric and suctioning tubes. Within a day and a half, he received 24 replies from health-care professionals across the United States. Today, Fraser is working on a Masters in Nursing at the University of Toronto and tweets a

To 'tweet' or not to 'tweet'

What would you do if a patient requested you to be one of her Facebook "friends?" Should you blog about a challenging client?

Rochelle Atkins, a policy and practice consultant at the College of Nurses of Ontario (CNO), says upholding practice standards such as confidentiality, consent, privacy, and maintaining appropriate therapeutic nurse/client relationships is just as important on Twitter as in a trauma unit.

Atkins says becoming 'friends' with a patient on a website like Facebook, which isn't set up for care-related communication, crosses professional limits laid out in the College's Therapeutic Nurse/Client Relationship Standard. "We expect nurses to maintain the boundary between a therapeutic nurse/client relationship and a friendship," Atkins explains. "Communication outside that becomes an issue."

Atkins says referring to individual patients or clients when blogging or tweeting is also inappropriate. Mentioning a patient's name, diagnosis, unique circumstances or any other information that makes it possible to identify an individual violates the *Personal Health Information Protection Act* (PHIPA). While most nurses would never consider breaching patient confidentiality in this way, a few do lose sight of their professional standards online.

Karen Puckrin, the CNO's Manager of Reports, says that in the past few years the College has received complaints and reports about nurses who have posted patients' conditions, treatment needs and even their names online. In one case, a patient contacted the College when he discovered his nurse had blogged about him.

"Every complaint is assessed individually," Puckrim says. "The College could ask a nurse to review practice standards or meet with CNO staff to discuss accountability for protecting a client's confidentiality." Puckrin also says nurses should follow a simple rule when online: if you wouldn't discuss something on a crowded elevator, you shouldn't post it on a website. **RN**

For more information on standards, call the CNO Practice Line at 1-800-387-5526 ext. 6397 or e-mail ppd@cnomail.org.

Social Media Demystified

A glossary of common terms to stay current in cyberspace.

Blog – or "web log" is a webpage that allows someone to write information, thoughts or stories about a particular topic, which other users can comment on.

Del.icio.us – allows you to save, categorize and share your favourite web pages. www.delicious.com

Digg – a community-based website where users submit content and rate it. The greater the number of "Diggs," an article earns, the more popular it is. www.digg.com

Facebook – users create and customize their own profiles with photos, videos and personal information. Users can send messages to 'friends' they've added, and update personal profiles. Visit RNAO's fan page at www.rnao.org/facebook

LinkedIn – is a business-oriented social networking site that allows professionals to connect with others in their field. www.linkedin.com

MySpace – an online community that allows friends to keep in touch and meet new people. You can create a profile and list interests, hobbies and share photos. www.myspace.com

Podcast – a digital media file distributed over the Internet. Listeners can play them on portable media players or a computer.

RSS – stands for Really Simple Syndication. RSS feeds are used to get the latest news from frequently updated websites.

Twitter – a free social networking website that allows users to send and read messages called tweets of up to 140 characters. www.twitter.com

Web 2.0 – describes changes in the way the World Wide Web is used to enhance information sharing and collaboration that has led to the development and evolution of social networking sites, video sharing sites and blogs.

Wiki – a page or collection of web pages designed to allow different people to contribute or modify content. Wikis are often used to create collaborative websites.

You Tube – a website where users can upload, view and share video clips. www.youtube.com **RN**

Source: http://www.alumni.mcgill.ca

few times a day to share articles, research studies and literature reviews.

Fraser also spends a good chunk of his online time updating Nursing Ideas, a website he created in 2008 that features videotaped interviews with nurse leaders, researchers, educators and other innovators like Toronto street nurse Cathy Crowe, and Tilda Shalof, an ICU nurse who has written a number of books on nursing. Fraser says he wants Nursing Ideas to make people aware of all the innovations happening in nursing.

"A lot of phenomenal things are happening within the profession," he explains. "But for the most part they're turned into difficult to read, sometimes very academic writing that takes a lot of the personal, passionate and more human aspects out of the story. I'm hoping to inspire nursing students and nurses to see the opportunities that are out there."

Kamini Kalia sends info on her iPhone.

Word about Fraser's enthusiasm for using social media to advance the profession is spreading. In November, he will give a presentation about Nursing Ideas at the Sigma Theta Tau International biennial convention in Indianapolis. And this fall, he'll be offering workshops through RNAO and the Registered Practical Nurses Association of Ontario to introduce nurses to Twitter, Facebook and other tools.

Fraser says one of the calmest places to enter the social media waters is LinkedIn, a professional site he likens to exchanging business cards at a conference. Users can post a resumé and express an interest in job offers, consulting or working with others. The site even has networking groups nurses can join and enables users to search for people they know. He also recommends RNs try out FriendFeed, which allows people to see everything someone is doing online. Searching for rdjfraser on FriendFeed, for example, takes you to his Nursing Ideas website, blog, and Twitter postings.

Fraser was barely a teenager when RN Barbara Cowie wrote an essay on how the Internet could be used for networking back in 1998. Cowie says experienced nurses shouldn't be intimidated by all the lingo and hype that surrounds Facebook or Twitter. You don't need to be under the age of 30 to take advantage of their potential.

"For collaboration and information sharing and networking with nurses who have similar interests, the Internet is phenomenal," she says.

Cowie recently completed an interprofessional education faculty and staff development program through the University of Toronto and St. Michael's Hospital. As part of the course, she often used a website called LinkHealthPro, a collaborative knowledge network, to stay in touch with other course participants from numerous organizations. Cowie and her fellow students could post their profiles and a list of research presentations and publications, ask questions of each other, and participate in discussion forums.

Cowie says the tools made it easier for her to learn. But she's aware that not all nurses are able to take advantage of these opportunities, especially those who live in remote areas of the province where Internet access can be spotty.

"I'm really cognizant about universal access and the inequalities; the differences between rural and urban and the need for more computer and Internet training," says Cowie. "We have to make sure that we address unequal access and develop infrastructures, services and education."

Using social media is now such an intrinsic part of their nursing careers that Cowie, Fraser and Kalia can't imagine life without it. Kalia says she wouldn't want to miss out on any of the advocacy and professional development she gets from tweeting.

"There are other discussions going on and other knowledge being circulated," she says. "It's almost as good as being able to go to a conference and talk to different people." And since she's purchased an iPhone, 'nursekama's' followers will now be able to read the nursing tweets she posts while she's on the city bus, at the yoga studio and everywhere in between. **RN**

JILL-MARIE BURKE IS ACTING STAFF WRITER AT RNAO.

Care after catastrophe

RNs share their experiences far from home to bring help and hope to people devastated by a natural disaster. *By Sandra Hodge & Valerie Rzepka*

It's early morning on Koh Phi Phi Don, a small island 50km from mainland Thailand in the Andaman Sea. The sharp, sweet scent of Durian fruit and the welcoming calls of "Saawasdee Kha!" from local merchants opening their shops fill the air. The warm sun and breeze blowing through the sparse palm trees scattered along the beach create a corner of paradise that belies the devastation of just six months ago.

It is June, 2005. We've now been here for nearly four months as part of a grassroots group called HI Phi Phi (Help International Phi-Phi) made up of volunteers from all over the world. We've come to help the people on this small, H-shaped island clean up after the Indian Ocean tsunami laid waste to their homes and workplaces. On Dec. 26 2004, the flat stretch of beach where most of the population lives was submerged under 15-foot waves. Nearly 2,000 of the 10,000 residents and tourists on Koh Phi Phi Don were killed that day, and many bodies were never recovered. Thousands more lost their homes, livelihoods, friends and family members.

ABOVE: Valerie Rzepka, (left), and Sandra Hodge turned a hotel lobby into a makeshift medical clinic to provide care to people in Thailand after a tsunami in 2004. **BELOW:** The inn that housed the clinic was one of the few buildings left standing after the disaster.

WHAT TO KNOW BEFORE YOU GO

Want to be an aid worker? Here are a few points to ponder.

- Research your destination, the local culture, and the emergency you're dealing with.
- Learn about the aid organization you're volunteering with. What are its values? Is the local community involved in the projects?
- Make sure your immunizations are current and get ready for a culture and gastronomic shock.
- Use a backpack rather than a suitcase. Don't forget steel toe boots, hand sanitizer, and a personal medical kit.
- Be open to change. The situation on the ground is often not as media reports make it seem.

"They put their lives on the line. I have nothing but gratitude for those nurses who served in times of need."

Photo courtesy: Corporal Simon Duchesne, Department of National Defence.

Nurse practitioner brings expertise to frontlines of battle

Retired major Lee-Anne Quinn saw more trauma during the two decades she spent working around the world than most Canadian nurses do during a lifetime at home. Quinn spent 22 years as a nurse practitioner in the Canadian Forces working with task forces in Somalia, Rwanda and Bosnia-Herzegovina. In 2007, she spent eight months in Kandahar, Afghanistan and quickly realized the mission was very different from anything she'd witnessed before.

"It's a war with big bombs and big injuries," Quinn says. "If you have a trauma come in, it's not an open fracture of a leg. The leg is blown off, the elbow is dislocated, the other arm or hand is missing and there are severe head and facial injuries. We were dealing with really catastrophic injuries."

Quinn worked at a multinational hospital with medical professionals from seven other nations to treat NATO soldiers, members of the Afghan National Army and Police as well as Afghan civilians caught in the crossfire. She says day-to-day life on the base was like something out of the 1970s television series MASH: 14 to 16-hour shifts for days on end; helicopters landing at the hospital's doors with injured soldiers on board; and once a week more than 35 casualties would arrive simultaneously and overwhelm the hospital's 12 trauma bays.

But Quinn was prepared for the work. She trained intensely with her trauma team so everyone was familiar with each other's skills. She also brushed up on her weapons and physical training. "That was incredibly important," she says, adding she was responsible for her own safety just like any other soldier.

Quinn officially retired from the Canadian Forces last year, and now works in Peterborough at a family practice where she cares for seniors and children. And as Remembrance Day approaches, she reflects on her own career and the dedication nurses had during the World Wars and the Korean War. **RN** *Stacey Hale is editorial assistant at RNAO.*

Working in the soggy rubble in Thailand was an opportunity for us to hone our nursing knowledge – and come up with some creative ways to provide care when supplies we would take for granted at home were non-existent. For Sandra Hodge, heading to Thailand was a logical part of a nursing career that has allowed her to rack up plenty of frequent-flyer points. She's ventured to places such as the Solomon Islands in the Pacific Ocean, the Australian Outback, and is currently fundraising to build schools in Myanmar. She's also spent time in some of the most remote parts of Canada, including the far reaches of the Northwest Territories and Rocky Mountains where she currently works. For me, Valerie Rzepka, the tsunami was my first opportunity to jump into international aid work. I've since helped people who have had their lives washed away or destroyed by nature's forces. I've worked with victims of earthquakes in Pakistan and China and cared for those who lost their livelihood after a typhoon and floods in Bangladesh. Today, both Sandra and I are part of Canadian Medical Assistance Teams, a volunteer disaster medical relief organization that is ready to spring into action at a moment's notice.

But on this sticky morning in Thailand, we're worried about making sure our patient will be able to make the commute to the mainland later today. Inside the clinic is a young man with a head injury who was brought in last night. He has been alert for the last few hours, and this morning he'll make the trip to the hospital on the next scheduled boat. The choppy, two-hour journey is the only choice when medievac helicopters are unable to fly. Our makeshift clinic was once the lobby of The Phi Phi Inn. A shell of the building is one of the few structures still partially standing on the island after the waters from the tsunami receded. The local owner donated use of the building to HI Phi Phi, whose members cleaned it, and re-installed electricity and plumbing. Although it's still primitive by Canadian standards, the hotel at least offers more room for the clinic than Sandra first had in February, 2005. Back then, it was just a small first aid station housed in the back room of a local beach bar. Now, four months later, Sandra is coordinating the HI Phi Phi clinic staffed by people from all over the world.

During the eight months the clinic was open, volunteers treated more than 5,000 patients for everything from basic infected cuts and scrapes to severe injuries caused by boat propellers. Bites and stings from local wildlife like jellyfish, snakes and spiders were also common. So were asthma attacks, allergic reactions and a variety of gastrointestinal and chest infections. We even coped with a minor outbreak of Dengue Fever, a mosquito-borne illness we both came down with. Sandra was battling a fever higher than 40 degrees C when she had to resuscitate and evacuate a man who had a heart attack while snorkelling.

During the spring of 2005, more primary care was needed as local people returned to the area. Many Thais believe a spirit will linger at a place where the body fell for 100 days after a death, and it should not be disturbed. When the mourning period ended, there was a major influx of people returning home to Koh Phi Phi Don. Suddenly, the need for medical personnel greatly increased because the island was still covered with twisted metal, broken glass, and debris. The potential for infection

was enormous since the tsunami had forced the contents of the sewer system over the island. We relied on donated funds to buy supplies in local shops and pharmacies, and on the equipment overseas volunteers brought with them to keep the clinic running. Some members of our team ended up staying in the area for more than a year. Our goal was always to hand back responsibility for medical care to the local community, and to help get the nearby hospital running again.

But there were still times when supplies were simply not available, and we had to make do with whatever we could. The island was without even basic emergency equipment such as a bag valve mask, intubation tubes, snake and rock fish antivenin, basic stretchers, and cervical collars. We relied on traditional medicine and unconventional methods locals taught us. Sea urchin stings, for example, would be treated by rolling the foot on pop bottles to break up the barbs from the spiky creature.

Discovering the locals' knowledge taught us how important it is to harness positive energy to create something good out of devastation. Foreign volunteers serve the communities best by completing projects in co-operation with the people who live there, and not for themselves. Communities affected by a disaster or a hardship have existed well before any volunteers arrived, and will continue to exist long after they leave. Relief work is about supporting the capacity of the people, engaging them in planning and goal setting. Locals often have the ability and knowledge to care for each other, but they may lack the funds. Monetary donations are always encouraged, but donors need to make sure their money actually goes where it's needed. Too often, we have seen well-meaning donations go to waste, including walkers donated to countries where jungles and beaches make them impossible to be used as anything but a plant trellis.

Despite these challenges, disaster relief provides countless rewards. People sometimes ask us why we would leave the comforts of the western world of nursing practice, where help is only an overhead page away, to work in geographically and politically isolated — sometimes even war-torn — pockets of human kind. Places where electricity and water supplies, if not scarce are, at least, unreliable. It is about having the chance to make a difference in just one person's life. Where there might have been despair in the face of an individual, to see that replaced with hope and relief is a gift beyond words. **RN**

RN SANDRA HODGE CURRENTLY WORKS BETWEEN JASPER, AB AND VALEMOUNT, BC AND IS COMPLETING HER NURSE PRACTITIONER DEGREE.VALERIE RZEPKA IS A TORONTO RN AND NURSING POLICY ANALYST AT RNAO.

EXPORTING NURSING KNOWLEDGE

RNAO is bringing its best practice guidelines (BPGs) around the world and learning from others through:

- Ongoing workshops for nurses in China.
- Workshops and speaking engagements in 30 countries.
- Selected BPGs have been translated into Italian, Mandarin and Japanese.
- In 2010, all the guidelines will be translated into Spanish.

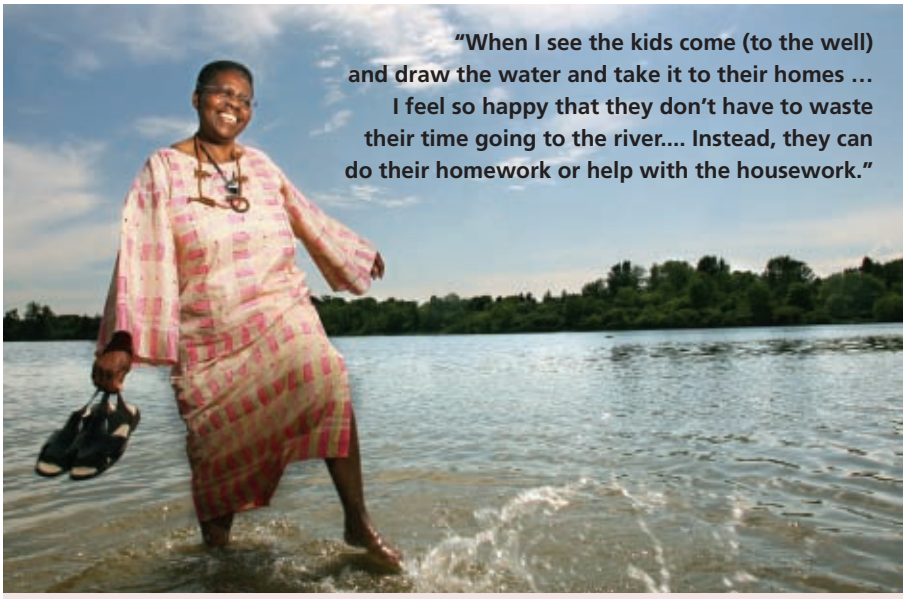


Photo courtesy: Julie Oliver/Ottawa Citizen. Reprinted by permission.

Water helps to keep African communities well

IN Ontario, rainy days dampen outdoor activities and drown out cottage weekends. But for Ottawa RN Bea Osome, they're a powerful reminder that women and children in two villages in her native Kenya aren't walking kilometres for water that often made them sick.

When Osome arrived in Canada in 1971, she was determined to find a way to provide clean water for people she left behind in her home village of Kiritu and Mumboha, the town where her husband grew up. For years, she approached organizations in Ottawa that build wells in Africa to ask for their help. When she discovered none of them organized projects in the southern-Kenyan villages, she knew she would have to spearhead the effort herself. She told friends and community groups how the resource we take for granted in Canada could save lives in Kenya, and asked them to consider making a donation. In 2008, she even collected donations from her fellow RNAO members. Countless small donations added up and today three wells are pumping.

Osome says clean water eliminates diarrhea and eye infections and is the key to preventing typhoid, cholera and malaria.

"If you have water nearby, people can wash themselves and wash the person who is ill to prevent cross-contamination or infection," explains the long-term care RN. "When people have malaria, drinking water will bring down the fever and may even prevent complications."

Osome says her mother regularly tells her about how grateful people in Kiritu are for the wells; they even include Osome in their prayers at church. The project is getting noticed in Canada as well. This summer, the *Ottawa Citizen* wrote about Osome's wells and *Ottawa Life* magazine named her to their 2009 list of Top 50 People in the Capital. Osome hopes the publicity will help her raise enough money to ensure that no one in Kenya will have to walk two or three kilometres to fetch dirty water. **RN** *Jill-Marie Burke is acting staff writer at RNAO.*

PROTECTING

YOU MAY NEVER NEED RNAO'S LEGAL ASSISTANCE PROGRAM, BUT IT CAN GUARD YOUR REPUTATION AND YOUR NURSING LICENCE IF YOU DO. BY JILL-MARIE BURKE

LAST MONTH, A PATIENT DIED DURING YOUR SHIFT. While you know you provided the woman with the best care you could, her daughter has filed a complaint against you with the College of Nurses of Ontario (CNO). She alleges you didn't assess or monitor her mother's condition properly. The day the woman died, your floor was short two nurses. You were run off your feet and are concerned your documentation isn't detailed enough. Your employer is supportive, but unwilling to provide legal representation. What do you do? If you're enrolled in RNAO's Legal Assistance Program (LAP), a phone call is all it will take to find out if you're eligible for legal advice.

Since 1986, LAP has helped more than 2,500 RNAO members, many of whom struggle with such situations. For $60 a year, the voluntary program helps RNAO members with legal problems related to work. That can include representation during CNO investigations, help if an RN is fired or being sexually harassed on the job, and advice if RNAO members need to testify at an inquest or inquiry.

Tim Hannigan is a lawyer and partner at Ryder Wright Blair & Holmes, a firm that specializes in employment law and has helped many nurses over the years through LAP. He says the majority of the nurses who seek his firm's counsel have had their employment terminated or are the subjects of a complaint to CNO. When nurses are fired, Hannigan says a lawyer can help them negotiate a reasonable severance package. But if the College of Nurses is investigating your work, he says it's important to call RNAO right away to get independent legal advice.

"A NURSE DOES NOT NECESSARILY HAVE TO DO SOMETHING WRONG TO BE THE SUBJECT OF A COMPLAINT ."

"A nurse does not necessarily have to do something wrong to be the subject of a complaint," Hannigan explains. "Nursing is a risky profession in the sense that you're dealing with members of the public who can complain in any number of circumstances."

RNAO first recognized that nurses need a legal assistance program during the Grange Inquiry. During 1983 and 1984, the royal commission investigated the suspicious deaths of more than 40 babies in the cardiac ward at the Hospital for Sick Children in Toronto. Nursing was front and centre during the inquiry, which followed charges of murder against a Sick Kids RN. Those charges were later dropped. But RNAO Executive Director Doris Grinspun says the inquiry demonstrated nurses need to protect themselves legally at all times.

"Prior to the Grange Inquiry, many nurses assumed that if they encountered legal difficulties at work, their employer would take care of them and provide the necessary assistance," Grinspun says. "The inquiry demonstrated that the employer doesn't necessarily have the same interest as the nurse. It taught nurses that it's absolutely necessary to protect their integrity as professionals in the health-care sector."

Twenty-five years have passed since the Grange Inquiry, but Hannigan says the legal lessons nurses learned from it still ring true today. He says if a health-care organization offers a nurse a lawyer's services, it's important to analyze the particulars of the situation before choosing this option.

"Nurses need to make sure they're looking out for their legal rights," he says. "If the employer is looking to protect itself, there may

Two decades of peace of mind

Since the 1980s, RNAO's Legal Assistance Program has helped thousands of members and marked some of its own milestones along the way.

1983-84
Grange Inquiry investigates the deaths of babies at Toronto's Hospital for Sick Children. Nurses become aware of the importance of legal protection that is independent of what their employers might offer.

1986
RNAO establishes the Legal Assistance program to provide members with help on professional legal issues. In June, LAP assists the first member with a complaint filed against her with the College of Nurses of Ontario.

1990
LAP begins providing brochures on topics including employment issues, testifying in court, and abuse.

2009
Seventy per cent of all RNAO members are covered by the Legal Assistance Plan.

your practice

be finger-pointing that goes on and it may be at an employee."

So what happens if you need LAP one day? The first step is to phone Lee Minty, the LAP administrator at RNAO home office. Minty listens to nurses' concerns to determine if the issue is actually a legal one and, if so, what type of action is required. If a member just needs legal information – and not a lawyer's advice or services – Minty will provide the necessary resources. She will also ask the caller if he or she is a union member because that's the first line of advice for many nurses. If the union can't help, LAP is the next step.

If the call is about a legal problem, Minty may authorize a consultation with a lawyer on behalf of the LAP committee, made up of RNAO members and a nurse lawyer who review numbered files that describe someone's case without identifying the person. If there is no need for further representation, the file is closed. But if members need more help, they will be advised on the next steps.

Minty says in order to qualify for LAP's help, you must keep up your RNAO membership and choose LAP every year. You must have been a member when the incident occurred, and right up through to when you call LAP. Minty believes LAP is an important membership benefit because you're eligible for assistance you even if you're not at work, something unions don't provide. If for example, you volunteer to be the nurse at your daughter's Brownie camp or perform CPR on a neighbour, LAP could cover you.

LAP committee member Liz Haugh saw nurses in difficult situations that required legal advice when she sat on the College of Nurses of Ontario's discipline committee. While she's never had to use LAP, she's happy to know the benefit is there if she needs it.

"As a nurse you never, ever know when you're going to need legal advice," she says. "We're dealing with people on a day-to-day basis and we're dealing with employment situations that are tenuous at times. LAP gives you peace of mind; the sense that, if anything did happen, at least you don't have to worry about taking out a mortgage on your house to pay a lawyer." **RN**

JILL-MARIE BURKE IS ACTING STAFF WRITER AT RNAO.

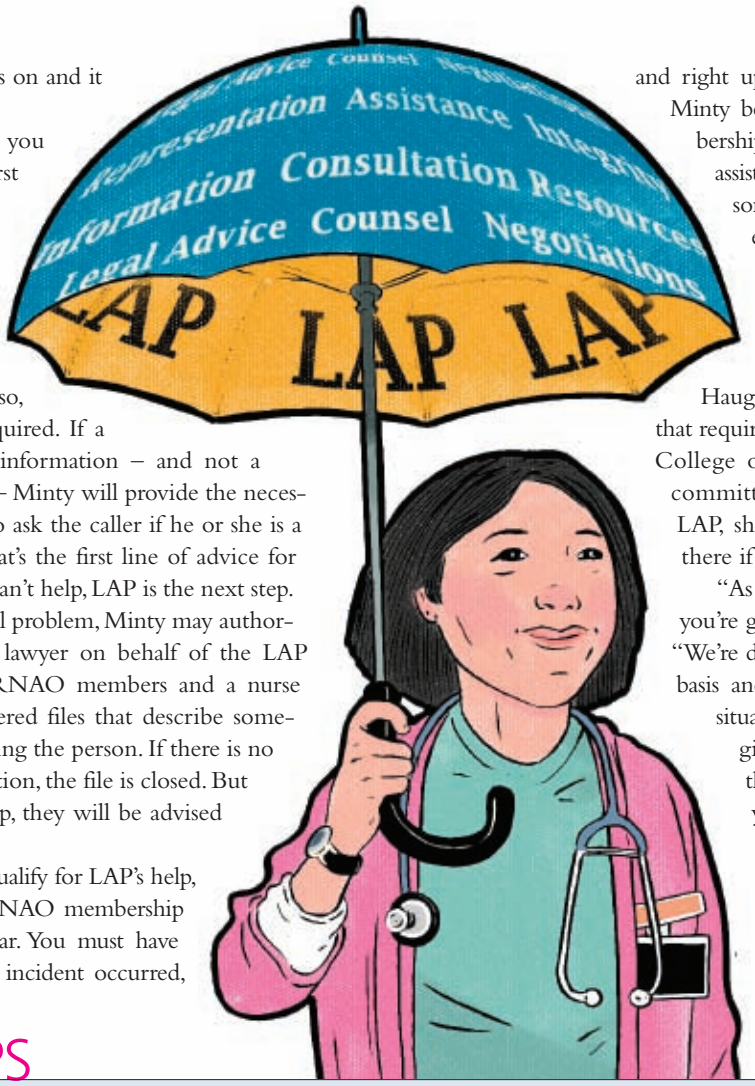


Illustration: Jason Schneider

LAP vs CNPS

Have you ever wondered what the differences are between LAP and coverage offered by the Canadian Nurses Protective Society (CNPS)? RNAO LAP administrator Lee Minty says RNs need both programs because they offer protection for different kinds of scenarios when nurses might need legal guidance.

CNPS: RNAO members are automatically eligible for assistance if they're being sued or facing criminal charges. Services are available free of charge.

LAP: May provide help if you're the subject of a complaint to the College of Nurses of Ontario. May offer advice with employment issues and provide support if you're asked to appear in court or at an inquest. LAP's cost is $60. If you are involved in a legal situation, you may be unsure about whether you need help from LAP, CNPS, or both. Minty can answer your questions, provide advice, discuss your options and walk you through the steps that need to be taken.

For more information, or to speak to Minty, call 1-800-567-4527 or e-mail lminty@rnao.org.

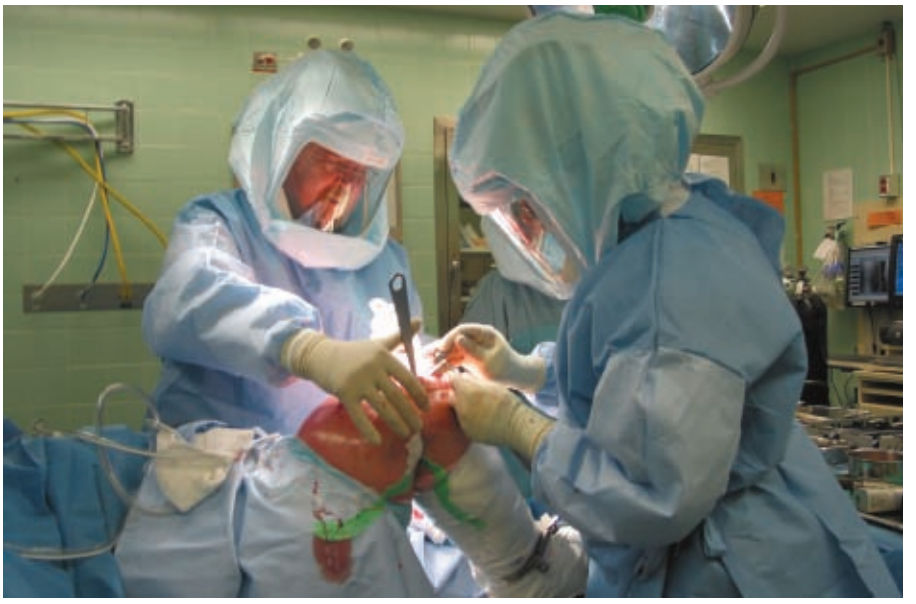
POLICY AT WORK

Why Physician Assistants aren't the answer

AS the Ministry of Health and Long-Term Care rolls out a pilot project to deploy physician assistants (PAs) across the province, RNAO is redoubling its efforts to show the public, government and media why PAs are not in patients' interests and that there is no place for them in our health-care system.

The facts are clear. Nurse practitioners (NPs) already do more than physician assistants could ever do in a clinical setting, and in a way that's safer and more cost efficient. NPs have better education, more clinical experience and greater professional autonomy than physician assistants. PAs must function under the direct supervision of a physician. Research already shows superior clinical outcomes for patients who received care from NPs as compared to PAs.

Of paramount concern to RNAO is the fact that patient care and safety are at risk of being compromised due to PAs' inadequate education and experience. While a new program at the University of Toronto does require students to have some experience in health care, the PA program offered at McMaster University does not. Both Ontario programs only require applicants to have two years of undergraduate study – not a full degree – in any discipline at some point in their past. Ontario PA students spend only one year in the classroom and another in general clinical education. RNAO believes this is a grossly inadequate education for a health-care worker when patient acuity is increasing and the public deserves and demands high professional standards of their care providers.



Tom Blunt, left, was one of the Registered Nurse First Assistants (RNFAs) who learned funding for the role will be extended after meetings between RNAO and the Minister of Health.

RNAO is also concerned that since PAs are unregulated, they are not subject to the high standards of practice governing regulated professionals. PAs are also not cost effective. At an average annual salary of $92,250 to $106,641 — plus additional bonuses and stipends of $72,000 over two years to the supervising physicians — Ontario taxpayers are not getting good value for their dollars.

PAs are touted as one way to ease wait times, but RNAO argues that hiring more NPs and allowing RNs and NPs to practise to their full scope would do much more to address challenges with access to care. A position statement on the role of PAs in Ontario's health-care system is expected to be approved by RNAO's board of directors this fall. **RN**

Broader powers for NPs

IN October, RNAO appeared before a public hearing to pursue amendments to address serious omissions in Bill 179, the Regulated Health Professions Statute Law Amendment Act, 2009. Premier McGuinty promised to broaden the scope of practice of nurse practitioners in April, but members were disappointed to learn the legislation doesn't address many key concerns. Most notable are the failure to move to open prescribing for NPs and not allowing them to admit, treat, and discharge hospital in-patients. Without these changes, RNAO argues the government will not be able to reduce surgical wait times or increase timely access to care. **RN**

Funding for RNFAs

Registered Nurse First Assistants received some good news this summer. In August, the Minister of Health and Long-Term Care announced funding for the positions would be maintained at the level of 50 per cent.

The government had considered cutting funding for this role, which would have eliminated many of the positions where these RNs are employed. RNFAs practise autonomously under the *Nursing Act* and provide assistance to patients and surgeons before, during and after surgical procedures.

Executive Director Doris Grinspun and President Wendy Fucile expressed their concerns about the funding cuts in private meetings and letters to Minister of Health and Long-Term Care, David Caplan, in April. RNAO hopes additional funding will enable the 80 available RNFAs in the province to secure full-time employment. Currently, only 39 are employed in full or part-time roles. RNAO has also asked the government to take its commitment to this role one step further by increasing funding for these positions to 100 per cent on a permanent basis and outside of hospital nursing budgets. **RN**

NEWS to You to Use

The Ontario Nurses' Association (ONA) has applied to the Supreme Court of Canada to appeal a decision that dismissed a lawsuit ONA filed on behalf of 53 nurses who contracted SARS in 2003. On May 7, the Ontario Court of Appeal ruled that the province did not owe a private duty of care to nurses who worked during SARS. ONA says the province assumed responsibility for the nurses' health and safety when it advised health-care workers on precautions to take during the outbreak.

In August, the College of Nurses of Ontario released a report on "nursing in the hallways." *Nursing in Temporary Locations: Listening to Ontario's Nurses* chronicles the challenges of upholding professional standards when overcrowding means patient care is being provided in corridors and utility rooms. The report can be found on the College's website, www.cno.org/nursinghalls.

This year marks the 25th anniversary of the Canada Health Act. The act was passed unanimously by Parliament in 1984, almost 40 years after Tommy Douglas first introduced publicly funded hospital care for people in Saskatchewan. The CHA established conditions that must be met before provinces can receive federal health funds and ensconced the principles of universality, public administration, comprehensiveness, portability and accessibility into the country's health-care system.

As Americans debated changes to their own health-care system this summer, myths about the care Canadians get in a single-payer system received plenty of publicity south of the border. Canadian Doctors for Medicare and Nurses for Medicare launched a website to counter some of those fictions. Mybettermedicare.ca supports publicly funded measures to strengthen health care, and invites members of the public to share their stories about the kind of care they've received.

RNAO's education and research committees are looking at how recent changes in funding are affecting nursing researchers and graduate students. More than 350 RNs participated in a survey to describe their experiences gaining resources for their work. The responses will help form the committees' work in pushing for nursing research dollars.

Thanks to persistence from RNAO Home Office, four Ontario nursing leaders and members of RNAO's Board of Directors are now part of a new provincial breastfeeding services and support working group. The group includes Theresa Agnew, Claudine Bennett, Ruth Schofield and Nancy Watters. The four were appointed after RNAO's lobbying efforts with both the Premier's office and the Minister of Health and Long-Term Care, and a meeting between the association and Charlotte Moore, the provincial lead on children's and maternal health.

On the heels of *Nurse Jackie's* first season comes *Mercy*, another medical television drama that stars nurses in the lead roles. The plot centres on Veronica Callahan, (below, third from left) a smart, capable nurse just back from a posting in Iraq. The show airs every Wednesday at 8 p.m. (ET) on City TV and NBC.

Photo: Courtesy Rogers Media Television

Calendar

October

October 22-23
6th Biennial Pediatric Nursing Conference: Child First, Patient Second
Crowne Plaza Hotel
Toronto, Ontario

November

November 6-8
Nurse Practitioners' Association of Ontario Annual Conference
Westin Ottawa
Ottawa, Ontario

November 23-27
Designing and Delivering Effective Education Programs
89 Chestnut Residence
Toronto, Ontario

December

December 2-4
International Affairs and Best Practice Guidelines: Transforming Nursing Through Knowledge – Sharing Global Visions and Local Solutions
The Westin Prince
Toronto, Ontario

DID YOU KNOW?

You can access the 'members only' section of the RNAO website to update your e-mail and mailing address. Never miss an issue of *Registered Nurse Journal* and stay connected with your nursing colleagues across the province. Update your profile today by visiting www.rnao.org/members.

Unless otherwise noted, for further information please contact events@rnao.org or call 1-800-268-7199.

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2010 ONTARIO FAMILY PRACTICE NURSES CONFERENCE

"COLLABORATION–The Model for the Future" April 23–24, 2010 - Hilton London Hotel. If you are a nurse in Primary Care or a nursing student, you won't want to miss this opportunity to network and participate in continuing education. **Call for Abstracts and Posters:** applications due by Oct. 30, 2009. For more information contact Melissa at 519.963.4415 or email: mbekker@kcimanagement.com.

The Nursing Retention Fund

ANNOUNCEMENT:

Accepting Applications for Funding

To all public hospitals in the Province of Ontario:

The Nursing Retention Fund (NRF) is designed to provide funds to public hospitals in Ontario for education/training as retention initiatives in circumstances where changes to hospital services may otherwise result in layoffs for nurses.

The NRF is a Ministry of Health and Long-Term Care initiative managed by the Ontario Nurses' Association (ONA), the Registered Nurses' Association of Ontario (RNAO), and the Registered Practical Nurses Association of Ontario (RPNAO).

The fund provides reimbursement to hospitals for the following:

- **cost of education/training required to retain nurses**
- **salary continuance (wages/salary and benefits) for a period of up to 6 months while nurses are attending education/training programs**

The NRF management committee is pleased to announce the extension of funding available through the fund to 2013. Following discussions between the NRF management committee and the Ministry of Health and Long-Term Care, the funding agreement has been amended to allow for broader eligibility for funding applicants.

Revisions have been made to the application process to provide guidance in the collection of data required to meet the eligibility criteria.

For more information about NRF, as well as application forms, please visit our website: www.nursingretentionfund.ca

You may also contact the NRF Project Coordinator at:
416-408-5592, 1-800-268-7199 x268, or
coordinator@nursingretentionfund.ca

RNAO ONA RPNAO Ontario

NURSING EDUCATION INITIATIVE

You may be eligible to receive up to $1,500 in tuition reimbursement! For pertinent deadline information or to obtain a copy of the application form, please **visit the RNAO website at www.rnao.org**

For the most current information about the Nursing Education Initiative, please contact:

RNAO's Frequently Asked Questions line
1-866-464-4405
OR
educationfunding@rnao.org

RNAO 85th AGM

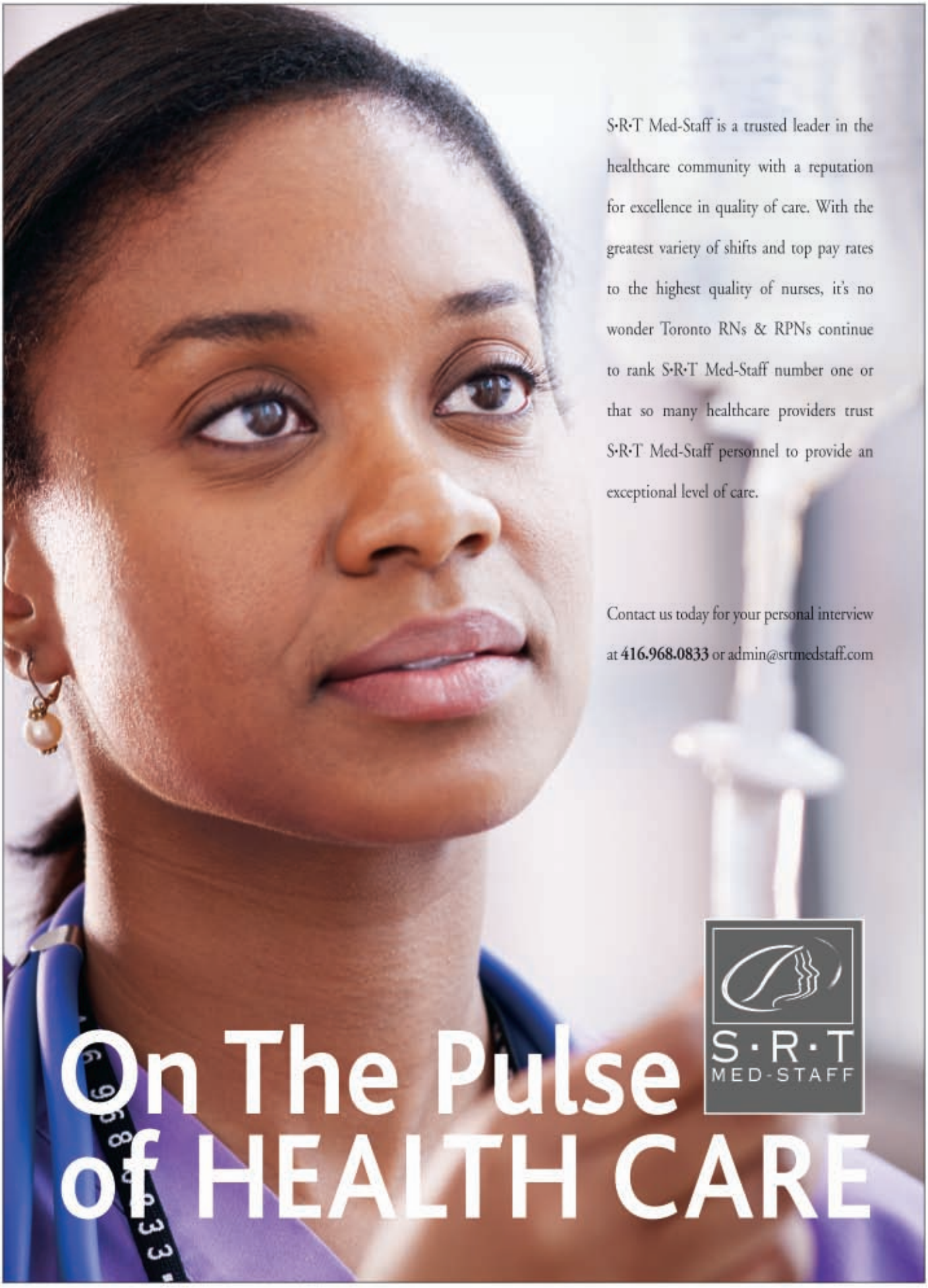
Next year's AGM is to be held on Friday, April 16, 2010 at the Downtown Hilton Toronto

Call for Resolutions
DEADLINE: Monday, Dec. 14, 2009 at 1700 hours (5:00 p.m.)

Call for Nominations 2010-2012
RNAO Board of Directors (BOD)
DEADLINE: Monday, Dec. 14, 2009 at 1700 hours (5:00 p.m.)

If you require further information, please see page 24 of the July/Aug issue of *Registered Nurse Journal* or contact Penny Lamanna, plamanna@rnao.org

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