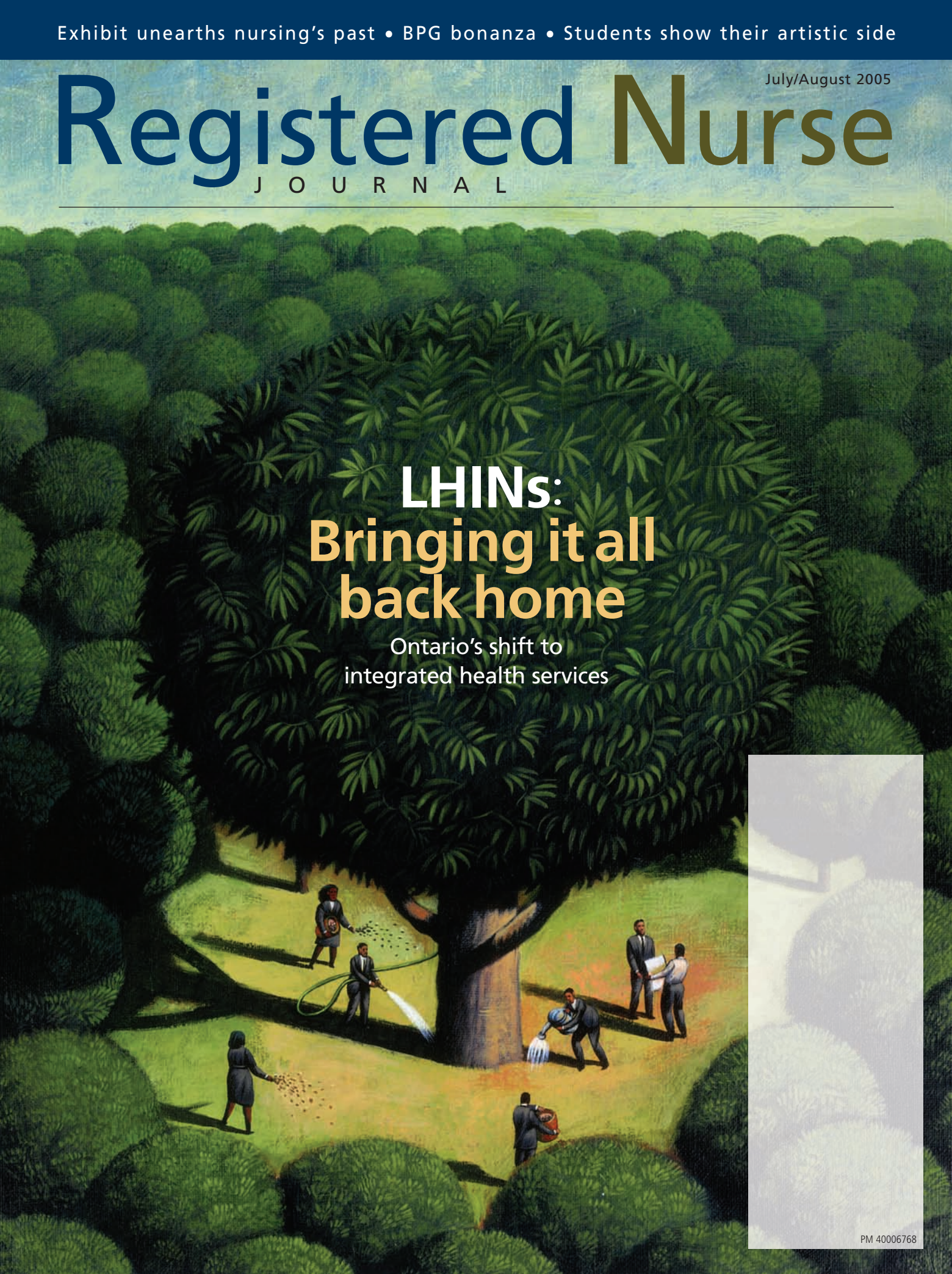
Exhibit unearths nursing's past • BPG bonanza • Students show their artistic side

July/August 2005

Registered Nurse JOURNAL



LHINs: Bringing it all back home

Ontario's shift to integrated health services

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Signs of renewal this September

At August's end, Ontarians heave a collective sigh as summer's close beckons. Labour Day hits and, before you know it, you're facing the additional responsibilities and quickened pace that come with September and the start of a new school year.

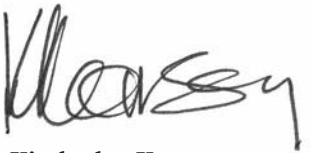
Fortunately, 'new starts' also bring the promise of change, and hopefully a renewed focus on strengthening professional practice.

This issue of *Registered Nurse Journal* looks back on the summer of 2005, and ahead to the challenges of reforming our health-care system.

Our President's View takes stock of some of the government's recent financial commitments to health-care transformation and better care and working conditions. The Executive Director's Dispatch and our feature on RNAO's Best Practice Guidelines (BPG) Program reinforce RNAO's ongoing commitment to evidence-based practice and its impact on improved patient care. And our cover feature takes an early look at the government's foray into providing more coordinated, regionally-based health care through building Local Health Integration Networks (LHIN).

As we head into the fall, we can expect to see nurses across the province making their own unique and independent contribution to reforming the health-care system. But just in case you need some inspiration, just refer to Anne Gilchrist's review of the Canadian Museum of Civilization's history of nursing exhibition in this issue. She ends the piece reflecting on one child's synopsis of hundreds of years of nursing: "Nurses are so cool" the child writes.

Is there any better inspiration to keep up the good work?



Kimberley Kearsey
Managing Editor (Acting)

Healthy reform afoot during summer's heat, but challenges await us in the fall

Whatever journeys RNAO members are on this summer – whether it's traveling with family or relaxing with friends, pursuing professional development, or continuing to enhance the health, comfort and quality of life of Ontarians – you should take heart that health-care reform has shown few signs of a summer slow-down.

Since the onset of summer, Health Minister George Smitherman has made a handful of announcements about investments to strengthen the community and long-term care sectors – essential prerequisites to ensuring the success of the government's health-care transformation agenda. The announcements have included: $58.3 million more for community-based mental health services; $112.7 million for home and community care services; $2.7 million to ensure new research and best practices help improve the health and the care of long-term care residents (see pg.7 for more on this); and a freeze in long-term care accommodation costs.

Hospitals have not been shut out of receiving good news either. On the first day of summer, individual hospitals received their first multi-year funding announcement in the province's history – an announcement that included at least $1.75 billion over three years in new funding for hospitals. Meanwhile, the creation of a new Ministry of Health Promotion could hold promise that public health may finally receive the attention and resources it deserves.

RNAO members, especially long-standing ones, will also likely be aware that on July 25th, Premier McGuinty announced $28 million for late-career nurses working in hospitals and long-term care homes. The investment gives Ontario's nurses who are older than 55 the chance to keep on nursing, but in less physically demanding roles, such as working as mentors, patient and family educators or staff advisors on clinical issues. This announcement is only one piece of the health human resource puzzle, but it is a critical piece if we are to retain the knowledge, expertise, wisdom and commitment of experienced nurses.

These announcements are obviously incremental and only drops in the health-care reform bucket. Some may even be viewed as re-announcements or roll-outs of previously proclaimed public investments. Neither do these announcements negate the anxiety of nurses whose jobs may be threatened during the government's balanced-budget process.

"It's important to ensure nurses' knowledge, expertise and experience continue to contribute to shaping the future of health care."

But it's important for nurses and the public they serve to recognize and support the government when it takes steps in the right direction along the winding road to reforming health care. The government's creation and initial staffing of one of its key reform initiatives – Local Health Integration Networks, or LHINs – may be a case in point. As executive director Doris Grinspun says in our cover piece (pg.12): "Anything that helps to create a more seamless, navigable and accessible system is a good thing….. We have to remember that LHINs are merely a tool, and we are all responsible for how they're used. As nurses, we need to be vigilant at this early stage to ensure LHINs evolve to strengthen medicare."

So as summer fades away and the fall beckons, nurses will have many questions to ask, issues to raise, and points to make to the government, to health-care employers, to each other, and of course to the public as we work together to improve the health-care system.

For instance, we will be looking to the Health Minister to announce this autumn that he will be implementing the best and strongest recommendations from Elinor Caplan's review of the competitive bidding process, including the elimination of the "elect to work" model that has marginalized home-care nurses for too long.

We will continue to press for protecting RNs from layoffs. We will be awaiting the latest statistics from the College of Nurses of Ontario to see how much closer we are to reaching the 70 per cent solution. We will urge government to invest funds to find positions for all of Ontario's new grads, and employers to hire them. We will monitor the government's progress on health-care reform to ensure nurses' knowledge, expertise and experience continue to contribute to shaping the future of health care. And, of course, we will be vigilant in our efforts to ensure two-tiered health-care does not take hold in Ontario or the rest of Canada.

In the meantime, enjoy the rest of your summer. Please make sure you renew your membership and bring many new members early in the fall. That way more RNs will continue to enjoy the myriad events and opportunities offered by RNAO. We will continue to serve our members with commitment, knowledge and passion.

JOAN LESMOND, RN, BScN, MSN, IS PRESIDENT OF RNAO.

Mailbag

The RNs role in ethical decision-making

Re: The case of Terry Schiavo, March/April 2005

I am always glad to see health policy and ethics as part of a conversation about health care. However, Anne Moorhouse's article about Terri Schiavo referenced outdated legislation. The *Consent to Treatment Act* was replaced by the *Health Care Consent Act* in 1996. While the principles and values are similar, there are differences in approach and application.

Moorhouse also indicates that "nurses and the clinical team are guided by the patient's wishes. If not known, the substitute decision-maker must decide what is in the patient's best interests." Nurses and the clinical team are guided by the patient's choices if she/he is capable of making the decision. If the patient is incapable, the substitute decision-maker must make the decision.

While it is helpful for nurses and the clinical team to know a patient's wishes, the nurses and clinical team must still turn to the patient's substitute decision-maker for guidance if the patient cannot make the decision for him/herself. Nurses and the clinical team cannot rely on knowledge of the patient's wishes to make a decision without the substitute decision-maker.

Dawn Oosterhoff, RN, LLB, SJD(c), ***Toronto***

Freedom, choice at stake in debate over public vs. private delivery of care

Re: Chaoulli ruling challenges us to remember how to keep Canada strong and free, President's View, May/June 2005

By enforcing one health-care system only, you are more or less discounting the right to choose. It also sets limitations on the right to pursue entrepreneurship, which opens the door to new services, creates jobs, increases the standard of living, increases the number of full-time positions, increases market demand and value for nurses, and creates more and greater opportunities.

As nurses we give our patients options, choices, and informed consent. But when it comes to health, there is only one way? Has the day arrived that we have turned off our professional objectivity? Two tier health care isn't a step back; it is a step forward because now we offer choice. By taking a stance to keep the status quo with slight revisions, we are showing a narrow and uncompromising view. We are endorsing the loss of freedom of choice. We are undermining our own principles as a profession devoted to looking at alternatives. Is this the future of nurses?

Craig Thompson, RN, ***Toronto***

CORRECTION

In our coverage of Nursing Week activities in the May/June issue of *Registered Nurse Journal*, we incorrectly identified Jean Warren as Jean Warner. We apologize for the error.

WE WANT TO HEAR FROM YOU.

Please e-mail letters to letters@rnao.org or fax 416-599-1926.

Margaret M. Allemang, RN, PhD
1914-2005

Margaret Allemang, an RNAO honorary life member and passionate nurse historian, passed away suddenly at her home on April 14. She was 90.

Margaret was dedicated to recording the lives and work of others. In late-1970, she began an oral history project to record the stories of nursing sisters who served during the First and Second World Wars.

"She had a lot of pride in the profession," remembers Judy Young, who completed her master's in nursing under Margaret's supervision.

John Allemang, Margaret's nephew, adds: "I think Margaret … saw in her own profession of nursing splendid examples of people who made major contributions to war and peace and health and humanity that for various reasons had been ignored or undervalued."

Margaret obtained her diploma in nursing from the University of Toronto (U of T) in 1940, and worked as assistant head nurse of the cancer unit at Toronto General Hospital before joining the Royal Canadian Air Force. After the war, she completed a BScN and a BA at U of T and taught nursing at Belleville General Hospital. In 1951, she began a 30-year teaching career at U of T. She earned her master's of nursing and PhD in education with a focus on the history of nursing education from the University of Washington in 1956 and 1974, respectively.

Margaret co-founded the *Canadian Association for the History of Nursing* and the *Ontario Society for the History of Nursing*, re-named the *Margaret M. Allemang Centre for the History of Nursing* in 1993. Natalie Riegler knew Margaret through their mutual interest in nursing history. She says the group decided to name the new centre after Margaret to honour her contribution to nursing history. Margaret's contributions also won other accolades, including the silver Jubilee medal in 1977 and the gold Queen's Jubilee medal in 2002.

Margaret's noteworthy efforts to preserve nursing's rich past will stand as one of her many legacies. **RN**

BPGs improving care, advancing evidence-based practice

When Health Minister George Smitherman announced earlier this month that his government was hiring eight regional coordinators to implement RNAO's Best Practice Guidelines (BPG) in long-term care homes, he signaled the government's recognition of – and commitment to – the two things RNAO's BPG program has been striving for since its inception six years ago: the full integration of evidence into everyday nursing practice and the full integration of evidence-based nursing care into everyday health policy. Both will undoubtedly result in improved patient care and outcomes.

This announcement signaled something else too: the government's recognition of the important work and unprecedented influence of the thousands of nurses – in all roles and sectors – who have been involved in the development, pilot testing, dissemination, uptake and evaluation of RNAO's 29 BPGs.

It is clear from Smitherman's commitment to use BPGs to achieve "improved quality of life for long-term care residents, more informed consumer participation, and higher standards of care," that RNAO's program is making a difference, and is influencing the policy directions and transformation agendas of Ontario's Liberal government. It is also clear that a program, with its beginnings under the financial backing of a different government, can survive a change in government and party if it is important to the system.

Indeed, the BPG Program began in 1999 under the leadership of then Minister of Health Elizabeth Witmer. The change in government in 2003 not only brought permanency to the BPG Program, but also increased funding from Premier McGuinty and Smitherman. This demonstrates that good programs can transcend partisan politics.

While we celebrate this recognition and harness this influence to move forward, we must also celebrate the influence and importance of BPGs on other fronts. RNAO's BPGs are not only driving positive directions in government; they are improving the day-to-day care nurses provide in Ontario, Canada and abroad. And, they are contributing to positive change in universities and colleges across the province.

"RNAO's BPGs are not only driving positive directions in government; they are improving day-to-day care."

Just look at the success of RNAO's BPG Champions Network, launched three years ago to improve understanding of the importance of BPGs, and to educate nurses on how to integrate BPGs into their daily practice to improve patients' health and clinical outcomes. By networking, sharing experiences, and building strong ties between organizations, these 519 Champions are influencing change at the point of care, and are generating enthusiasm and passion for evidence-based practice and best patient care.

BPGs cover the full breadth of nursing practice: from health promotion and disease prevention to restorative, curative and palliative nursing care; from clinical areas to relational ones. Guidelines range from dealing with obesity, post-partum depression and smoking cessation, to preventing and treating pressure ulcers, to client-centred care, to our newest program on healthy work environments. They are influential because of their quality, their relevance, and their applicability in all sectors of health care and with so many different populations – here at home and around the world.

Ontario's BPGs are reaching nursing communities nationally and internationally. You will soon hear the results of a joint partnership with Linda Piazza and the Canadian Nurses Foundation that will see at least three organizations awarded funds to evaluate implementation of RNAO's BPG in jurisdictions outside of Ontario.

On the international scene, our guidelines are posted on the World Health Organization (WHO) Web site and on the Web sites of organizations such as evidencebasednursing.it in Italy. RNAO's 3rd bi-annual BPG international conference and our popular BPG Summer Institute (a full week of learning) attracted delegates from as far away as Australia, England, the Netherlands and Scotland.

As important as teaching our international partners has become, we haven't forgotten how vital it is to also teach nursing students right here at home. Eleven nursing programs in Ontario received $10,000 each in 2004 to incorporate BPGs into curriculum. Some of those schools shared their amazing experiences at the BPG conference (see pg. 17). It's exciting to envision a health-care system in which so many new nursing graduates enter the workforce expecting, rather than wondering, if they will provide high quality patient care through BPGs. However, we must heed some nursing academics who worry that new grads must not lose sight of BPGs when they enter the workforce. There's still much work to be done to ensure BPGs are implemented in all workplaces across Ontario and around the world. Without implementation, patients will not get the quality care they deserve, and nurses will not practice to their fullest potential.

It's exciting to think about what we've achieved since 1999. It's even more exciting to think of what we can achieve in the years to come.

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

by **Jill Shaw**

Nursing in the news

RNAO & RNs weigh in on . . .

National Post, Monday, July 25, 2005, Letter to the Editor

Public health's perks

Re: Business Leaders Urge Health Care Changes: System 'Broken,' July 20.
The vast majority of Ontarians know and understand how important our single-tier, public health care system is to our health and to our economy.

Perhaps the Ontario Chamber of Commerce members who responded to their survey on privatization have not quite caught on.

Perhaps those who responded don't know that evidence and experience from other jurisdictions show that whatever problems our health care system has will only be worsened by a parallel private health care system that threatens to siphon nurses, doctors, resources and support from the public system and to privilege those who can afford to pay for private health care. Perhaps they don't know of the evidence on how much more efficient and less expensive a single-payer health care system is.

Ontario's registered nurses have asked Premier Dalton McGuinty to remind all other premiers of this evidence when he meets his colleagues in Alberta next month at the Council of the Federation meeting. We have urged the Premier to rally his fellow premiers to reject the regressive push for parallel, private health care and emerge from next month's Council of the Federation meeting with an unequivocal commitment to universal, single-tier health care. That commitment is imperative, especially in light of the Supreme Court's Chaoulli decision, which has already elicited laudatory comments from those who believe they can line their pockets as a result of the decision.

As we evaluate the Chamber's survey results, let us keep one question in mind: What do most business owners think? We believe most business people share the opinion of most Ontarians that universal access to medicare is a public good, and that public health care is better for the economy than an expensive and inefficient private system that jeopardizes medicare.

Joan Lesmond, RN, BScN, MSN, president,
Registered Nurses' Association of Ontario, Toronto.

Keeping experienced nurses on the job

In July, the McGuinty government announced $28 million to allow nurses over the age of 50 to spend 20 per cent of their working time in less physically demanding roles, opening up more time for mentoring younger nurses or educating patients. RNAO executive director **Doris Grinspun** responded on *CHML AM* – Hamilton (July 26), and RNAO members told local media outlets what that funding would mean for their careers.

• **Lorraine Lamarche** told the *Cornwall Standard-Freeholder* she is now considering working part-time instead of full retirement, and the funding for late-career initiatives will benefit younger nurses who can learn from their colleagues. "Not everything in health care can be taught in a classroom or in a textbook, so I can see the benefits of this program in the future." **Heather Arthur** added her perspective to the story, noting the funding will help alleviate the nursing shortage (July 26).

• **Paul-André Gauthier, Jackie Andrew, Pat Somers, Christine Cass, Annette Jones** and **Rhonda Crocker** provided reaction from the front lines on *CBC French* Radio – Sudbury, *CKLW AM* – Windsor, *CHEX TV* – Peterborough, *CKVR TV* – Barrie, *CHWI TV* – Windsor, *CFPL TV* – London, and *CBQ FM* – Thunder Bay (July 25/26).

The 70 per cent solution

Following the June 14 release of *The 70 per cent Solution*, RNAO president **Joan Lesmond** spoke to *Toronto Sun* columnist Dave Chilton about the health benefits of increasing the percentage of full-time nurses. "It's to ensure that there's continuity, to minimize sick time, and also to have a positive impact on health care," she said, adding, "…so nurses would not be running in different settings, doing four different jobs to (create) a full-time job." (June 29)

Screening for abuse

In response to a *Hamilton Spectator* story about how health workers deal with abuse victims, RNAO BPG project director **Tazim Virani** wrote a letter to the editor, educating readers about RNAO's nursing best practice guideline, *Woman Abuse: Screening, Identification and Initial Response*. "Considering RNs are a woman's first point of contact with the health-care system, it's clear nurses are key to ensuring women get the care they need. The guideline includes practice, education, and policy recommendations for nurses and nursing organizations in all health-care settings." (June 7)

For complete versions
of any of these stories, contact
Jill Shaw at jshaw@rnao.org.

Feeding the hungry

RNAO executive director **Doris Grinspun** applauded a City of Toronto decision to allow nurse practitioners (NP) to sign forms authorizing welfare recipients to receive up to an additional $250 per month to meet special diet needs. She told the *Toronto Star* the decision is recognition of nurses' strong knowledge base. NPs and doctors can now sign the forms for individuals who suffer from medical conditions such as diabetes, hypertension and cystic fibrosis (July 26).

Assisting with surgery

RNAO member **Marion Reid** spoke to the press about registered nurse first assistants (RNFA) helping surgeons, and how their contribution in the OR can help ease the shortage of physicians, especially in rural Ontario. **Brenda Koivula**, an RNFA who graduated in 2004, added that a training program in Ontario, and positions for those who gain their certifications, are vital to the role being adopted across the province (*Markham Economist & Sun, Vaughan Citizen, Aurora Era/Banner, Richmond Hill Liberal*, July 21).

Innovation in nursing education

• RNAO member **Joan Tranmer** said new curriculum at Queen's University, which emphasizes teaching health professionals to work together and share expertise, will improve patient care and use of health-care resources. "Right now, doctors and nurses are educated in all these little schools but all of a sudden they graduate and have to work in health-care teams." (*Kingston Whig-Standard*, July 4)

• RNAO member **Lesley Brown** said Confederation College's decision to offer nursing at its Kenora campus will help the local hospital retain young staff and ease some of the difficulties of replacing senior staff and covering vacations (*Kenora Daily Miner & News*, June 22).

NPs coming to British Columbia

Michelle Clifford-Middel offered *The Vancouver Courier* Ontario's experience with NPs in an article about the role. She said once Ontarians understand what NPs can do, they begin seeking their care. "Nurse practitioners bridge that gap between what an RN can provide and what the physician is able to provide. I think that's a pretty efficient use of the dollar." Legislation is expected this summer to make the NP role official in British Columbia (July 4).

Psychiatric nursing

In an article about psychiatric nursing, RNAO board member **Elsabeth Jensen** said the relationships between psychiatric nurses working in the community and their patients is fundamental to the patient's well being. "Nursing is about the continuity of relationships and support. That is the age-old role of nursing. And that support is so necessary to enable people with psychiatric diagnoses to get along." (*Toronto Star*, July 8)

Out & About

RNAO president Joan Lesmond was at Trinity St. Paul's United Church in Toronto on June 30th to support Global White Band Day. The event saw landmarks around the world wrapped in white bands as part of a Make Poverty History campaign to which RNAO has lent its support. Lesmond (centre) celebrates the launch of the campaign with Canadian Crossroads International's Elizabeth Dove, Ontario regional director (left) and Christine Campbell, director of development and communications. As part of the festivities, a white banner was lifted to the top of the church, and it remained there for one week.

Welcoming new nurses

Scott Hebb, one of the first graduates from the Fanshawe College and University of Western Ontario collaborative nursing program, said deciding to become a nurse after a career in gardening seemed logical. "I'm a nurturer – my focus has just shifted from plants to people." (*London Free Press*, June 18)

Caring for children

• RNAO executive director **Doris Grinspun** told the *Toronto Star* that political wranlging to get the Shriners to build a new children's hospital was embarrassing. In response to the name calling and celebrity endorsements, she told the *Star*, "Ontario and the rest of the country should be able to provide services and facilities without needing to rely on charity or the private sector." (July 8)

• In a column in the *Globe and Mail*, RNAO member and Hospital for Sick Children president and CEO **Mary Jo Haddad** wrote that children's health cannot be ignored in the debate over health-care reform; investing in children's care will save health dollars when those children are adults, but it requires targeted funding and political will: "… National health-care reform strategies ignore children. While they target adult wait-times for cancer care, heart care, hip replacements and cataract surgery, our children wait for subspecialists like pediatric neurologists and pediatric oncologists." (July 19)

• **Julie Bisson** told the *Daily Press* – Timmins – that the local TV Turnoff Week event was a big success. About 80 per cent of children from one school participating in the program were successful (June 30).

Breathing easy

• RNAO member **Katherine Wolsey** said Kingston General Hospital decided to become scent free out of respect for those who report migraines, fatigue and asthma attacks when exposed to fragrances from perfumes, deodorants and aftershave (*Kingston Whig-Standard*, June 18).

• **Jennifer Olajos-Clow** said young asthmatic children suffer the most on smoggy days because they breathe quickly and have small airways (*Kingston Whig-Standard*, June 16).

Heart care at home

Christine Struthers said 40 new telehome units, will enable nurses to monitor and treat heart patients at home. It is not the miles that count. It is the trouble of people getting here." (*Daily Observer* - Pembroke, July 7).

Illustration: Isabelle Cardinal/agoodson.com

On May 13, RNAO member Edith Martel (right), a nurse at the Muncey Health Centre outside of London, received a Health Canada First Nations and Inuit Health Branch (FNIHB) Nursing Award of Excellence, presented by Carolyn Bennett (left), Minister of State (Public Health). Martel was nominated by colleagues for her 28 years of nursing work in outpost nursing and community health in Manitoba, Saskatchewan and Ontario.

May 13 also marked Aboriginal Nurses Day, and the launch of an Aboriginal Nurses Association of Canada (ANAC) public awareness campaign to promote nursing as a career choice for First Nations students in grades six to 12.

by Jill Shaw

Express admitting helps ease ER workload

Why Nursing?

Mary Timms became an RN because she wanted a career with unlimited possibilities. In her late twenties, she was working in computers but decided to switch gears and pursue nursing, a profession with more diversity. After obtaining her nursing diploma from George Brown College in 1978, Timms landed a job in critical care at a hospital on Prince Edward Island. She worked there until 1981, when she returned to Ontario to begin a summer job in the emergency department at Peterborough Regional Health Centre (PRHC). With the exception of a one-year stint nursing in Texas in 1994, Timms has spent 24 years at PRHC, primarily in emergency. She was part of the sexual assault team and became a sexual assault nurse examiner in the late 1990s. She also occasionally nursed on different hospital units on a temporary basis.

"My heart was always in critical care or emergency," she says. "But I believe you have to appreciate other people's jobs."

In 2003, that love of critical care led Timms to help develop and work on PRHC's patient transfer team and, in 2004, to apply for one of two positions on the new Patient Express Admitting Team, or PEAT.

Responsibilities:

Launched last December, PEAT is unique in Ontario and modeled after a similar program in New Jersey. It's aim is to unclog the emergency department.

"Emergency has become impossible to run because there's a backlog of in-patients," Timms says, adding that patients sometimes feel the admissions process is fragmented and confusing. As a PEAT nurse, Timms holds some of those fragments together.

Name: Mary Timms
Occupation: RN, Patient Express Admitting Team
Home Town: Peterborough, Ontario

PEAT patients are usually medical or surgical admissions who have a hospitalist – a doctor who only sees admitted patients – assigned to them. The patient or family members must also be able to interact with the PEAT nurse and be willing to complete a survey about the admission process to help PRHC monitor PEAT's progress.

Approximately 12 to 15 patients a day are eligible for PEAT. Timms spends over an hour with each patient completing a full medical history, explaining the tests or procedures a patient can expect to undergo, starting medications, screening for respiratory diseases, and keeping family members updated on their loved ones' care. Timms also notifies community agencies if patients will need community services once they are discharged. Once a PEAT patient leaves Timms' care and is sent to the appropriate floor in the hospital, staff on that floor has his or her thorough medical history and a completed admission screening, and can direct any questions about the patient to the admitting PEAT nurse.

Challenges:

Timms says she and one other PEAT nurse work regular weekday shifts, and can only see medical/surgical patients who have recently arrived in the busy emergency department. More than 80,000 people visit PRHC's emergency room every year, and if a patient has been in the emergency room over the weekend, most of the required admissions work is already done. Timms hopes PEAT will be able to hire more nurses once the program demonstrates progress in areas like reducing emergency waiting times, improving infection control practices and easing patient anxiety.

Memories of a job well done:

Timms says PEAT is working. Initial surveys show it has slightly decreased the length of stay for pneumonia and Chronic Obstructive Pulmonary Disease patients. Feedback from other hospital staff indicates PEAT nurses free ER staff from some administrative duties, allowing them more time to spend with patients. There is also improved communication between the ER and other floors. For Timms, the most personal reward comes from working one-on-one with patients and providing them with continuity of care.

"Patients feel informed," she says. "If they know I'm the PEAT nurse and I've looked after them, they are able to ask for me if they have any questions."

Future plans:

Timms hopes the program will continue to reduce waiting times and lower lengths of stay. She hopes to see more PEAT nurses caring for more than just medical/surgical patients. There has also been some interest in the program from other hospitals. In July, Halton Healthcare Services visited to learn more about PEAT, and a hospital in St. John's, Newfoundland has also expressed interest in the program.

But while PEAT is growing, Timms is nearing retirement. She doesn't think she could ever retire completely from nursing and is still open to change. She would like to use her training as a sexual assault nurse examiner to provide education in the community, and has contemplated doing outpost nursing for a short time to link nursing with her love of the outdoors.

"I've always been game to try something new," she says. "Today, nursing has unlimited possibilities." **RN**

JILL SHAW IS ACTING COMMUNICATIONS OFFICER/WRITER AT RNAO.

by Anila Sunnak

LHINs: Bringing it all back home

Ontario's shift to integrated health services

Last September, Ontario's Health Minister George Smitherman outlined the government's three-year health-care transformation agenda, announcing that Local Health Integration Networks (LHIN) will play a pivotal role in ensuring health care in Ontario is more patient-focused, results-driven, integrated and sustainable.

"We are creating LHINs because local health services are best planned at the local level, by people familiar with the needs of a community," Smitherman said. "We need local expertise from right across Ontario to help plan and co-ordinate the health-care services that are right for people in different communities."

LHINs will serve as the government's main building blocks for achieving system integration under the management of RN Gail Paech, past-president or RNAO and the lead for system integration for the Ministry of Health and Long-Term Care (MOHLTC). The LHINs will be responsible for planning, integrating and funding local health services, including hospitals, community care access centres, home care, long-term care, mental health, community health centres, and addiction and community support services. Each of the 14 LHINs announced last September will operate within a specific geographic area. During the development of the LHINs, the province's 16 district health councils were disbanded and dissolved at the end of March, 2005.

Scheduled to start their work this fall, the LHINs' responsibilities will evolve over the next two years with an initial focus on planning and setting priorities before the networks begin to allocate funding for services. They will operate under five founding principles: equity of access; preserving patient choice; measurable outcomes; community-focused care responsive to local health needs; and shared accountability between providers, government, community and citizens.

The latest news on LHINs came in June with the appointment of 14 new Chief Executive Officers (CEO), plus 42 board members, including chairs and directors. RNAO is pleased that the initial appointments include nine accomplished RNs, five of whom are RNAO members (see pg.16). The government plans to fill each LHIN board with nine members by the end of the year. RNAO president Joan Lesmond spoke at a central east LHINs meeting August 12 and reminded those in attendance that the boards should be reflective of the diversity of the populations they serve.

While Ontario's LHINs are still a work-in-progress, some newly appointed RNs see the overall policy direction as a very positive step. RNAO member and ER nurse, Kim Stasiak, is a member of the Hamilton Niagara Haldimand Brant LHIN. "This truly is an historic endeavor for Ontario. We have great hope and enthusiasm for what the LHINs can do," she says.

RNAO member Jean Trimnell, CEO of the North Simcoe Muskoka LHIN, is also optimistic. She says her board will meet in late August to discuss key local health-care

"To succeed, regionalization needs a clear mandate, committed partners, outstanding leaders, and a vision that will mobilize providers and the public." — *Steven Lewis*

needs and priorities identified during the Ministry's community workshops held last November and December. "I think there will now be a greater ability to facilitate the sharing of best practices and knowledge quickly within and across LHINs," she adds.

RNAO member Pat Mandy, CEO of the Hamilton Niagara Haldimand Brant LHIN, says her nursing background will guide her work. "The values of respect, caring, accountability, innovation and the importance of patient-centred care will be key to decision-making," she says.

While the government has praised its own political leadership in moving towards regionalization, the reality is that Ontario has long held the distinction of being the only province left to decentralize health care. What does this late-in-coming – but potentially significant – policy shift mean for nurses in Ontario? How will it change working relationships, roles and responsibilities?

Detailed answers to these essential questions have yet to surface, but we do know that Ontario's regionalization will allow for more population-based health-care planning that holds the promise for more tailored programming and better tracking of health outcomes. It is hoped that this new emphasis on community-planned health care will improve the coordination of services within the system. As front-line professionals, RNs know all-too-well the negative costs of fragmented health-care delivery out of touch with local needs. As a first priority for the Hamilton Niagara Haldimand Brant LHIN, Stasiak says: "A common thread exists throughout the province, and that is the wait times and staffing shortages we face in all our communities."

The more general question of what Ontario can expect and learn from other provinces' experience with regionalization elicits more comprehensive answers.

Health-care regionalization 'Canadian style' garners mixed reviews from experts in the field. For instance, distinguished Canadian health-care policy analyst Steven Lewis writes: "At first glance it (regionalization) appears radical and bold, but on closer inspection it has been incremental and constrained." He also maintains that its full potential has not been fully realized partly because governments and the public have not given the new regional entities enough independence.

The *Canadian Centre for the Analysis of Regionalization and Health Care* (CCARH) notes that regionalization has taken hold across Canada as a result of numerous provincial health-care commissions and task forces over the past 20 years.

Lewis and co-author and CCARH director Denise Kouri note that most Canadian provinces have transferred health care to Regional Health Authorities (RHA) in the hopes of achieving more cost savings, greater efficiency, equity of access, local input, increased accountability and a greater emphasis on prevention and health promotion.

Toronto-based health-care analyst Michael

What are LHINs?

RN Gail Paech is Lead, System Integration (LHINs) at Ontario's Ministry of Health and Long-Term Care (MOHLTC). She is part of the seven-member Health Results Team, created by Health Minister George Smitherman in September 2004.

RNJ: How does the government's LHINs initiative fit into its overall goal to transform health care in Ontario?
GP: With the creation of the LHINs we are looking to bring about greater integration and coordination of health-care services. Right now, we have hospitals, long-term care agencies, community agencies and CCACs, and nobody is really planning or working together to develop a whole continuum of care. LHINs are an important part of the evolution of health care from a collection of services to a true health-care system. The other main objective is to be more clearly focused on the patient, client, or individual's health-care needs.

RNJ: Can you tell us a bit more about your role in coordinating and overseeing the LHIN process? How does your RN background inform your perspective?
GP: I've spent over 35 years working in the health-care system … in education, research, management and consulting. I've been an ADM since 1998, served as a CEO of the Toronto East General Hospital and past-president of RNAO. My RN background means that I bring a very patient-centred perspective to this exercise. My other experience has helped to develop a systems approach or understanding of health care. I think both views are needed to move our system forward.

RNJ: How does Ontario's model for regionalization compare with other models in Canada?
GP: Ontario's model is unique but perhaps most similar to Quebec's. This government recognized very clearly that local governance – meaning the boards that are providing governance to hospitals, long-term care facilities, and the CCACs – is critically important. Local leaders are the real strength of the Ontario system. In other regional models, the RHAs (Regional Health Authorities) are both the provider and funder of care. In Ontario, these governance functions will remain separate. LHINs will not be providers of clinical services.

RNJ: Will the LHINs mirror the CCACs in Ontario and use a competitive bidding process to allot contracts in their region?
GP: No, we're really not into competitive bidding. However, there will be more clearly defined funding…outlining how much money is available to hospitals for priority procedures like cataracts, hips, and knees.

RNJ: In June, the government appointed board members and CEOs to the 14 LHINs.

Ontario has long held the distinction of being the only province left to decentralize health care.

Rachlis notes that RHAs in the smaller provinces tend to serve areas of less than 100,000 on average. In Ontario, the new LHINs will serve between 250,000 and 1.5 million people. According to Paech, "These boundaries will in no way prevent people from seeking health-care services outside their own LHIN area. People will continue to be able to choose where they want to get their care as they do today."

Paech also insists LHINs will respect and retain the autonomy of current governance structures: "We've learned a lot by looking at RHA models across Canada, and feel strongly that LHINs will not take over the day-to-day provision of health-care services. Local leaders are the real strength of the system and need to be independent to continue to do these jobs well."

While all provinces have appointed RHA boards, most have also created community advisory boards and other mechanisms to ensure public participation. For example, Alberta's *Community Health Councils* and Quebec's *People's Forums* are mandated to regularly consult the public to ensure local health needs are met.

Across Canada, ongoing political and policy negotiations between the RHAs and the province are inherently complex, slow, and dependent on scarce funding. It doesn't help that most of them have been operating under ongoing restructuring as provinces continually redefine regional boundaries. This is another reason Lewis notes that regionalization has yet to achieve its full potential anywhere in Canada.

Despite these reservations, regionalization does offer promise. Lewis pinpoints its fundamental strength: "The single most vital characteristic of a region is that it is a defined population within a defined geographic area."

While more study is needed on regionalized health care, Canadian policy analyst and University of Calgary professor Ann Casebeer sees some positive and proven outcomes of regionalization to date. Among them: less duplication of services in hospitals; increased integration; and the ability to be more responsive and innovative in the health-care arena. Regional structures by their very mandate also offer the promise of more ongoing community dialogue on health care.

RNAO member Georgina Thompson, newly appointed Chair of the South East LHIN, says: "Our first priority will be to introduce ourselves to our communities and establish new relationships with health-care organizations and community members. This will be a necessary first step to accomplish what we need to do."

RNAO member Gwen DuBois-Wing, CEO for the North West LHIN, notes: "LHINs will build on existing strengths of the system and work together with our communities, consumers and providers to identify those elements of the health system where we can move forward to better integrate and coordinate services."

In Ontario, RNAO Executive Director Doris Grinspun explains why the association is supportive of the government's LHINs

Was there any discussion about having elected representation on these boards?
GP: A couple of other provinces had experimented with elected members and it was mostly unsuccessful. So the decision was made to go with an appointed process. The reality is that these boards are critical decision makers for our system and these individuals must have the right skill-set. However, the government will also eventually bring in a process to allow the community to nominate three of the board members for approval.

RNJ: Can you tell us more about MOHLTC's stewardship role vis-a-vis the LIHNs?
GP: The Ministry will determine the vision, standards and budget allocation for the LHINs. The province provides the overall framework and the LHINs move it out into the community, recognizing the complexities or special needs of that geographic region. The relationship between the government and each LHIN covering operational, financial, auditing and reporting requirements will be outlined in a memorandum of understanding and annual performance agreements.

RNJ: Will adopting regionalization through LHINs reduce health-care costs in Ontario?
GP: I have to be clear that LHINs are not a cost-cutting exercise. The government understands that health care is a huge expenditure, but we need to slow down its seven to 10 per cent per annum growth rate. Clearly, we need to make health care more efficient and accountable and we hope regionalization will help to accomplish this.

RNJ: How will the ministry ensure LHINs are accountable to act in the best interests of the community?
GP: LHINs will be governed by an appointed Board of Directors and bound by performance agreements with the ministry. This means they will be responsible for evaluating and reporting on their progress. Ultimately we also have accountability through our democratic electoral process.

RNJ: Can you give us a sense of some upcoming LHINs events/milestones?
GP: We now have 14 Integration Priority Reports to kick- start the work of each LHIN. The reports (posted on MOHLTC's Web site) are the result of the ministry's 14 LHIN community workshops held across Ontario las year. Approximately 4,000 people attended the workshops. This August we'll be starting a community engagement process across the province. LHIN boards led by the CEOs and chairs will start a meet-and-greet process to begin asking their local communities what some of the health-care priorities should be in each region. This public consultation will take about a year given how big some of these regions are and the time it'll take to co-ordinate this process. Also, this fall we'll be bringing in enabling legislation to clarify the roles of the LHINs. We expect that the LHINs will be fully operational by 2007. **RN**

Five RNAO members lend expertise to LHINs

RNAO congratulates the following members who have been appointed to the LHINs board:

- Gwen Dubois-Wing, CEO (North West)
- Patricia Mandy. CEO (Hamilton Niagara Haldimand Brant)
- Kim Stasiak, Member, (Hamilton Niagara Haldimand Brant)
- Georgina Thompson, Chair (South East)
- Jean Trimnell, CEO (North Simcoe Muskoka)

For a complete list, visit www.health.gov.on.ca/transformation

reform. "Anything that helps to create a more seamless, navigable and accessible system is a good thing," she says, adding that one key point still needs clarification. "My main concern is that if competitive bidding is introduced by LHINs as it was through the Community Care Access Centres (CCACs), it could mean the expansion of private, for-profit health care. We have to remember that LHINs are merely a tool, and we are all responsible for how they're used. As nurses, we need to be vigilant at this early stage to ensure LHINs evolve to strengthen Medicare."

While Ontario's LHINs are still a work-in-progress, some newly appointed RNs see the overall policy direction as a very positive step.

Paech acknowledges the concern and is clear that competitive bidding is not planned.

As noted by CCARH and others, there has been too little evaluation of the country's many RHAs to provide conclusive lessons for Ontario, but six prescriptive points emerge as key to achieving vital regionalized health care.

First, a stable, transparent and accountable government-LHIN relationship is key. Government must support contentious or unpopular decisions at the local level to avoid the politicization of the process, especially since LHIN boards consist of political appointees. Stasiak is hopeful about the potential for greater accountability in the new system. "The new accountability agreements will ensure that the services offered by the providers under the LHIN are maintained, with good patient outcomes. This will mean that public dollars are being utilized properly to provide essential services."

Lewis says it also helps to measure and report on performance at the seams of the system. "For example, how well hospitals hand off care to the community, or how easy it is for people to figure out where to go for service, etc. More practically, there has to be accountability for achieving the main objectives of the LHINs instead of merely rhetorical declarations of intent."

Second, a needs-based funding model is essential to align resources to needs. Many provinces are already working on this, but only British Columbia, Alberta and Saskatchewan have adopted a needs-based funding formula. Lewis argues that needs-based funding is critical, but no formula is perfect.

"Everyone needs to understand what the rules are and why certain decisions have been made." Needs-based funding relies on objective factors such as population base, the specific health needs of the district, and patient traffic across regions.

The third prerequisite calls for the need to foster a culture of innovation in health care. As Paech says: "We need to move from working competitively to working collaboratively. We also need to think of what is best for the system rather than our own particular agency, hospital, or little patch of health care. Incentives encouraging innovation will be key but are yet to be worked out."

Thompson is already confident the new system will result in new ways of working together. "LHINs will create an opportunity that doesn't exist now for different health providers to work as a team, to plan and coordinate local health services with one common group of patients in mind," she says. Mandy emphasizes that LHINS will also increase the efficiency and responsiveness of the system because of less duplication and a new focus on providing coordinated care.

Setting up new, more responsive regional health-care networks requires improved information management. For the newly appointed LHINs members to do an effective job, health information has to be accessible, timely and up-to-date.

One of Canada's foremost health-care analysts and University of Toronto professor Colleen Flood emphasizes what she thinks is another key to a successful transition to regionalized health care: that physician services and drug budgets be brought under RHA or LHIN control. She writes: "Who can manage effectively without control of all the significant levers?" So far, no province has had the political will to make this move.

Finally, Lewis says LHINs must be free to experiment. "LHINs need to have the flexibility to experiment and even to fail on occasion, as long as they are accountable for performance and are willing to admit mistakes and correct them. Governments have a tendency to micromanage funding and set expectations for volumes of services and processes of care rather than outcomes."

Although it's not yet clear what regionalization might mean for RNs, Lewis's early appraisal of what Ontario can expect from regional reforms best sums up the imperfect truth: "The aims are laudable, but it remains to be seen if the means are sufficient to achieve these ends. Ontario has the country's most fragmented health-care system. Given the political realities of health care in Ontario, it may well be that LHINs constitute the best step forward at this time. But it's probably optimistic to anticipate dramatic improvements in coordination, efficiency, and redistribution of resources to improve health care any time soon." **RN**

ANILA SUNNAK IS A FREELANCE WRITER IN TORONTO.

by **Jill Shaw**

BPGs: From Boardroom *to bedside*

RNs across Ontario and around the world share success stories and offer inspiration to nurses confronting the challenge of best practice implementation.

RN Beth Hamer, lead of the best practice consult group at Penatanguishene Mental Health Centre (PMHC), knew RNAO's crisis intervention best practice guideline (BPG) would make a big difference in the lives of her patients. That's because many of them have already been diagnosed with a mental illness, live and function well in the community, but come to the centre overwhelmed by situational crises such as losing their apartment, the break-up of a relationship, or the death of a friend or family member. Mental illness can be exacerbated by such crises, but Hamer says the guideline may help patients get their lives back.

With a $12,000 grant through RNAO's Advanced Clinical/Practice Fellowships for Nurses, and a matching grant from the health centre, Hamer implemented the crisis intervention guideline on PMHC's admissions assessment unit. With support from three staff nurses on the unit, she approached the admissions staff with plans to implement the guideline. Hamer admits to some initial front-line resistance.

"Staff nurses have a tremendous amount of work already," she says. "They worry this is just another thing (to do)… and (wonder), will it be utilized?"

Securing the support and buy-in of staff is not the only challenge facing nurses who bring guidelines into the workplace. The adoption of accessible and user-friendly technological devices that aid in the application of BPGs – things like Personal Digital Assistants (PDA) – is another challenge, as is the vital need to increase awareness among nurses and administrators of the importance of BPGs, and the opportunities they afford.

Hamer helped raise awareness when she

Delegates from the U.K., Australia and the Netherlands visited RNAO in late May to discuss ways of identifying, critiquing and influencing international trends in BPG development, implementation and evaluation. Pictured (L to R): (front row) Irmajean Bajnok, Director, RNAO Centre for Professional Nursing Excellence; Margaret Harrison, Associate Professor, Queen's University; RNAO Executive Director Doris Grinspun; (back row) William Gray, Research and Development Fellow, Quality Improvement Programme, Royal College of Nursing Institute, UK; Heather McConnell, BPG Program Manager; Tazim Virani, Director, BPG Program; Josephine Santos, BPG Program Coordinator; Bernice West, Research Director, Robert Gordon University, UK; Rick Wiechula, Director of Operations, The Joanna Briggs Institute, Australia; Barbara Davies, Associate Professor, University of Ottawa; Kirsten Krull-Naraj, VP, Patient Care Services and Chief Nursing Officer, Royal Victoria Hospital; Stephanie Lappan-Gracon, BPG Champions Network; Herry In Den Bosch, Project Manager, LEVV The Netherlands Centre for Excellence in Nursing; and Jane Schouten, BPG Program Coordinator.

shared her story with nursing colleagues in June at RNAO's international BPG conference, *Best Practice Guidelines: The Key to Knowledge Practice Synergy*. She was among 45 presenters offering insights into the challenges of BPG implementation, and sharing useful and innovative approaches to successful take-up.

Funded by the Ministry of Health and Long-Term Care, RNAO's Nursing Best Practice Guidelines (BPG) Program has brought together hundreds of experts to share their extensive knowledge on topics ranging from postpartum depression and breastfeeding to falls prevention to pain management and assessment. The Program has released 29 guidelines since 1999, and continues to lead the way in evidence-based care in Ontario, Canada and abroad.

Six years into the Program, one thing has become clear: BPGs translate directly into improved patient care on the front lines, and nurses at the bedside are now strongly receptive to implementating BPGs.

One year ago, Hamer's team embarked on a 20-week plan to implement the crisis intervention guideline. Based on comparisons done before and after the crisis intervention education and the guideline implementation, Hamer says there has been a noticeable change in patient care. Patients now leave the health centre with a clearly defined plan that helps them identify a priority problem and find solutions. For instance, a patient who has lost his home will talk to a nurse about goals, personal strengths and coping methods needed to get his life back on track.

"This is a big switch," Hamer says. "In the old days, the patient would come in and ... say, 'what are you going to do for me?' We've turned this around, and they are now supported to help themselves."

Sharing that kind of success with colleagues, and offering inspiration to get past the stumbling blocks of implementation, was the primary purpose of RNAO's BPG conference in June, says Tazim Virani, director of the BPG program.

"Organizations can address challenges in a number of ways," Virani says of the varied approaches explored at the conference. "They can identify clinical gaps and appropriate guideline recommendations to implement … conduct an environmental assessment to address barriers and facilitators, select evidence-based implementation strategies to ensure the necessary resources are there." Whether those resources are financial, educational or technological, she says they are all necessary to successful implementation.

Diane Doran, interim dean of nursing at the University of Toronto, shares her perspective on one of those 'necessary resources' that can define success or failure when implementing BPGs: the importance of adopting accessible and user-friendly technology in the application of BPGs. This need became obvious to Doran when she conducted a study for the Ministry of Health and Long-Term Care in 2002 and 2003. The study found nurses who document information about patient outcomes are more focused on those outcomes as patient goals. Doran realized there had to be a more efficient way of tracking those outcomes than the traditional pencil-and-paper method.

That realization gave birth to a follow-up study called *Outcomes in the Palm of Your Hand: Improving the Quality and Continuity of Patient Care*, a study to test the usability of Personal Digital Assistants (or PDAs) to monitor patients and apply BPGs in real time among a group of home and acute-care nurses.

In the study's first phase, the *Risk Assessment and Prevention of Pressure Ulcers* and *Assessment and Management of Pain* BPGs will be interpreted into a computer-based language that nurses can access on PDAs. For instance, a nurse would enter data about a patient confined to bed rest, and the software would use the Braden Scale for Predicting Pressure Sore Risk to calculate that patient's risk of a bed sore. The nurse could then link directly to a relevant RNAO BPG recommendation that would pop up on the screen.

"It's customized to their patient's situation," says Doran. "Nurses don't have to leave the room and look for resources; they have that information right at their fingertips."

Doran will continue her research to determine if having instant access to BPGs motivates nurses to change their practice, or if it changes patient outcomes.

"The biggest drawback for us in nursing right now is that we don't rely enough on defensible evidence to guide our practice," Doran says. "It's absolutely essential that we find ways to enable nurses more ready access to this evidence."

"Yes, there are challenges with every change," says Doris Grinspun, RNAO executive director and the founder of Ontario's BPG Program. She counters firmly, however,

PhD fellow explores environmental influences on nursing care

For Amy Bender, last year's winner of the Nursing Best Practice Guidelines PhD Fellowship, it's not only important to teach nurses about guidelines, it's also important to consider where nurses care for patients, and how those environments affect the implementation of the *Establishing Therapeutic Relationships* guideline.

As part of her PhD dissertation proposal, which will examine relationships in public health, Bender is also exploring how the places in the community where nurses practice affect nurse/client relationships.

Upon successful defense of her proposal, Bender hopes to begin interviewing and observing nurses and their clients in the tuberculosis program of public health early next year. Since tuberculosis clients tend to be homeless or new to Canada, Bender says this will allow her to examine not only how physical locations impact nurse-client relationships but also the role social structures play in the development of those relationship.

She says understanding the reality of nurse/client relationships will go a long way toward closing the gap between nursing theory and practice, and implementing the therapeutic relationships guideline in the public health context.

Bender, who was a mental health consultant in public health before becoming a full-time PhD student at the University of Toronto, says nurses recognize that nurse/client relationships are important, but often take them for granted and spend little time discussing the skills involved, especially when those relationships happen in non-traditional places like clients' homes or homeless shelters. **RN**

that nurses' passion for patient care outweighs any possible challenge. "Let's continue to tap into that passion, and facilitate its expression through inspiring work environments. We will see uptake of BPGs continue to increase day by day. And not only will patients emerge winners, but nurses will also gain more and more respect for their clinical knowledge."

According to Kathryn Higuchi, an assistant professor of nursing at the University of Ottawa, giving nurses access to evidence and promoting the advantages of evidence-based practice begins in school. Higuchi, along with fellow professors Betty Cragg and Denyse Pharand and other colleagues, decided to help faculty learn more about BPGs – and how to implement them – across the University of Ottawa, Algonquin College and La Cité Collégiale collaborative nursing program. Using surveys, focus groups and interviews, they found many instructors either weren't aware of the guidelines, were confused about the difference between the guidelines and College of Nurses of Ontario standards, or felt guidelines were too unwieldy to teach effectively.

To address these concerns, Higuchi and her team obtained funding from RNAO to demonstrate how BPGs are integrated into nursing curriculum. They held workshops in February 2004 and again five months later, asking participants to critique the guidelines to understand their complexities and to discuss ways to implement components of relevant guidelines into the classroom and clinical settings. "What goes on in the practice area is so powerful," Higuchi says. "If we're talking about new trends in the classroom and students don't see it in practice, or if it's not being reinforced by clinical instructors, students question what we say in the classroom."

Higuchi says she will continue to build awareness of BPGs on an ad hoc basis. The collaborative curriculum monitoring committee will also check if guidelines are being used in the classroom wherever possible, and Higuchi says she has already heard anecdotally that many teachers are incorporating guidelines into their courses.

"I think the BPGs have really opened the door to encouraging and enhancing the independent decision making of nurses," she says.

For more information on BPGs, visit: www.rnao.org/bestpractices/. **RN**

JILL SHAW IS ACTING COMMUNICATIONS OFFICER/WRITER AT RNAO.

Bringing BPGs to Life

Behind every best practice guideline, you will find the faces of nurses and patients. Thanks to Toronto's Artword Theatre and the AfriCan Theatre Ensemble, those faces had a voice at RNAO's best practice guidelines conference in June, where nurses were treated to an hour-long dramatic presentation called *RNAO Best Practice Stories*.

Ronald Weihs, resident director of AfriCan and artistic director of Artword, learned of the conference and the best practice guideline program from Thomas Baker, a composer and musician who was approached by RNAO to present the guidelines creatively. The AfriCan actors brought the guidelines to life through a performance that had conference participants laughing, crying and cheering as they recognized their own experiences in the stories.

"At first it was overwhelming," he says of creating the performance. "Then, suddenly, I started to realize …. there were some very exciting ideas."

Working with Baker, the AfriCan actors, a designer and Artword's managing director Judith Sandiford, Weihs began exploring the relationships between nurses and patients presented in some guidelines. It took nearly a month to find poems, songs and nurses' stories from books and Web sites; the group then wrote music and a script to dramatize the stories in a series of skits. Among the faces in this ambitious project: a woman caring for her grandfather, a decorated Second World War veteran now suffering from Alzheimer's disease; and a survivor of abuse who posted her personal, horrifying attacks at the hands of her partner on a Web site. In the skit, the woman visited a nurse twice. The first time, she hesitated at the thought of telling the RN about the abuse, but when she visited later with another problem, she told the nurse everything and sang about her struggle to begin taking control of her life.

Through these and other powerful stories, Weihs says the theatre group hoped to stimulate discussion about the heart-wrenching circumstances patients can sometimes find themselves in, and how nurses can use the guidelines to help them.

AfriCan Theatre Ensemble and Artword Theatre will also perform at November's *Healthy Workplaces in Action* conference on Nov. 17 and 18. **RN**

Actors from AfriCan Theatre Ensemble and Artword Theatre bring BPG stories to life at the conference. They created five skits with assistance and guidance from BPG Program director Tazim Virani and Sylvia Ralphs-Thibodeau, a panel member for RNAO's childhood obesity guideline.

by Jill Shaw

An exercise in expression

Nursing students get their fingers dirty with glue and paint as they harness their artistic abilities and share their placement experiences through art.

Third-year community health nursing practice students in the Ryerson, Centennial and George Brown collaborative nursing degree program did something different for their final submissions for this year's reflective practice projects, an assignment to prepare them for the College of Nurses' reflective practice requirement for practicing nurses. In addition to traditional academic pieces, students created everything from cross-stitches to puzzles to masks and clay carvings as they looked back on their community practice placements.

RNAO member Laurie Clune, a faculty member at Ryerson, says this kind of learning and expression can help students articulate thoughts and feelings more easily than they might in academic papers. Although students still had to complete several written reflections, their final reflections could use any medium to capture what they learned about community nursing. Although some students were hesitatant to do an alternative reflection at first, many chose to complete one once they realized they didn't need to be artists.

"Nursing has to be creative," says RNAO member Corinne Hart, third-year lead teacher. "It's an opportunity for them to realize … that not everything has to come from what they've learned out of a book."

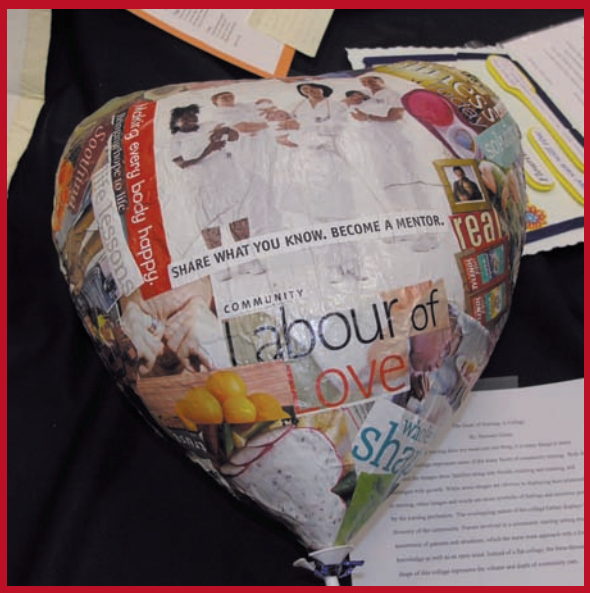
Steven Mark can attest to that. He spent six weeks in the oncology clinic at Toronto East General Hospital, where he created a presentation on health promotion and prevention for colorectal cancer patients. The experience also made him realize that patients' emotions need recognition.

Mark's empathy for patients was also stirred by his mother, who died of colon cancer in 2004. For his reflection, he created three masks to represent patients' experiences during diagnosis, chemotherapy and remission. Mark brought the masks to life during a presentation to his peers and faculty that included lighting and music.

"Feelings and emotions are sometimes not given the same priorities as the next medical assessment or treatment," he says. "I thought I could make a difference by having (the masks) as part of my teaching and communicating with clients."

Mark says he doesn't see himself as an artist, but he was willing to take a risk and build the masks. Mark's project received plenty of positive feedback, including interest from a professor to present it at an international conference.

Hart says the third-year nursing faculty members were so impressed with the quality of work presented that they plan to integrate this additional approach into next year's program. **RN**



Top Left: Heiwete Girma covers a heart-shaped, helium balloon with a collage of concepts representing what it means to be a nurse – mentoring, sharing life lessons and comforting patients.

Bottom Left: A ball trapped inside a transparent box shows the constraints Agnes Tsang noticed during her three-week placement in a Catholic school. The words covering the ball represent different areas of community health nursing. The strings attached to the ball pull at nurses in the same way many of the professions' tensions tug at nurses, binding them to barriers represented by the transparent walls around the ball.

Top Right: Archna Patel enlisted fellow classmates to help her assemble this puzzle of a garden representing the different, integrated aspects of community health. The soil, water and sun help community health to flower.

Bottom Right: Maria Veronica S. Paras illustrates how language barriers can become barriers to care in a multi-cultural country like Canada, where English is a second language for many citizens.

And the nurse sees a reflection

Reflection. For many of us, the very word conjures up a variety of images: the seasoned nurse, recognizing her social and professional status, admiring her accomplishments, confident in her contributions thus far; the mid-career nurse, wincing with trepidation, uncertain whether her efforts conform to a nursing ideal; and the novice nurse, defiant at a reflection that causes her to appear insignificant within an imposing environment.

In many respects, nurses are a reflection of a broad social milieu, for it is the nurse who must ensure the imperative of human caring is not subsumed under resource limitation, technological advancement, and stringent expectations from a complex health-care system.

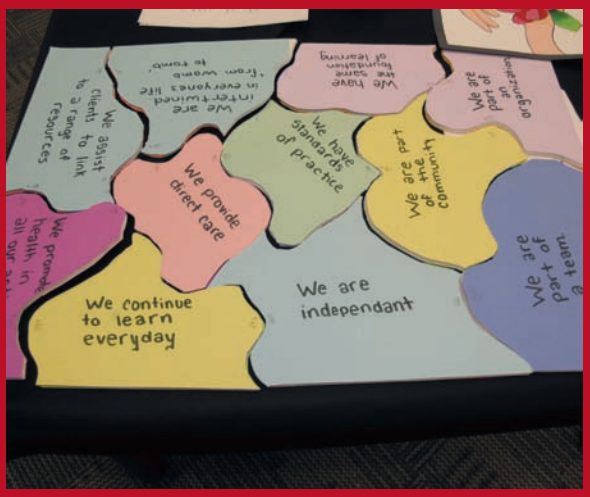
For each nurse, the reflection of self may be warped by many factors beyond our control. Yet, the continuing advancement of nursing demands an unflinching view of ourselves – a view that counteracts prevailing misconceptions of our profession and promotes nursing as a career in which caring is central.

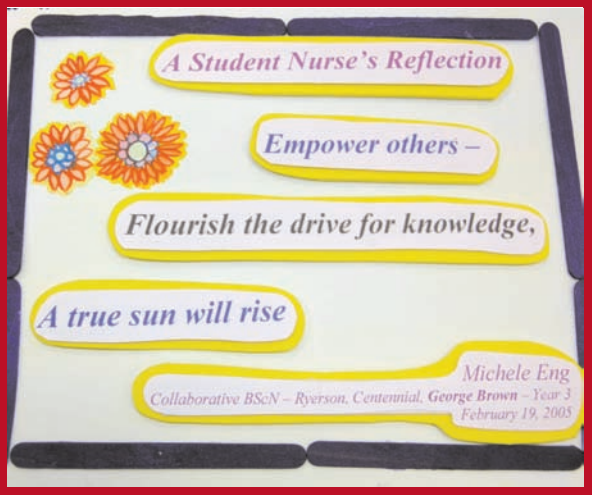
As the College of Nurses of Ontario (CNO) declares, each day of nursing practice requires reflection. Through our disparate roles within the structure of health care – in the community or hospital setting, or as instructors in the academic environment – nurses often serve as luminaries. It is the nurse who is privy to emerging changes in resource allocation; the nurse who is able to identify areas of client need that are not being met; the nurse who is able to sense the air of disillusionment confronting students whose ideal of nursing is challenged by the realities of nursing practice.

Reflection is the very thrust of effective nursing, enabling a review of past actions, and providing the opportunity to improve future trials, or to re-affirm the appropriateness of prior responses. Through reflective practice and peer interaction, nurses are able to apply the power of collective action to effecting social and political change, enhancing our capacity to challenge the status quo which impedes nurses' ability to realize their potential.

Reflection. Only through acknowledging the significance of this aspect of nursing practice can nurses maintain the imperative of human caring which is fundamental to our profession.

CARIL SEBASTIAN, B.SC.(UWI), SN(IV), IS A RYERSON UNIVERSITY NURSING STUDENT WHOSE FIRST DEGREE WAS IN BIOLOGY. BEFORE EMBARKING ON STUDIES IN NURSING, SEBASTIAN WAS A PAN AMERICAN HEALTH ORGANIZATION (PAHO) PROJECT MANAGER AND RESEARCHER FOR LATIN AMERICA AND THE CARIBBEAN.



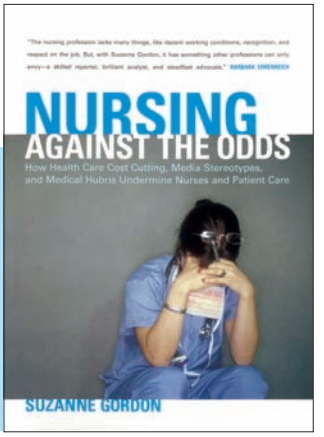


Top: Nikita Kandola created a large double-sided puzzle to show how the different characteristics and traits of a nurse fit together.
Middle: Michele Eng describes nursing through a traditional Japanese poem called a haiku.
Bottom: Steven Mark fashioned three masks to represent colorectal cancer patients' experiences during diagnosis, treatment and remission.

by Kimberley Kearsey

Q&A with Suzanne Gordon

For almost 20 years, Suzanne Gordon has been writing about troubling trends in nursing and health care. In May, she released her latest book, *Nursing Against the Odds: How Health Care Cost Cutting, Media Stereotypes, and Medical Hubris Undermine Nurses and Patient Care*. She talks to *Registered Nurse Journal* about how RNs can advocate for themselves and their patients, and how education and awareness will help create a health-care environment in which positive change is not only possible, but probable.



RNJ: *In your book you compare nurses in an unstable health-care system to navigators on a volatile sea. Where does this analogy come from, and why is it fitting?*

SG: I borrow that analogy from political anthropologist James C. Scott who talks about the difference between a ship's pilot and captain. The captain gets the ship across the ocean. When the captain wants to get the ship into port, he always transfers control to the pilot who knows the local conditions. The transfer is an acknowledgment of interdependence. If you look at a doctor and a nurse…the practice is the same. The doctor will diagnose and do the treatment or the surgery. But if the patient is going to get into the port of health…a nurse is critical.

RNJ: *You refer to nurses as "rescue workers" in your book. How do RNs respond to that comparison?*

SG: I believe nurses rescue patients from the risks and consequences of illness, its treatment, and from the fact that both illness and treatment make it hard for patients to do the things they would do on their own. Even the compassionate and caring work that nurses do is part of that rescue work because that's rescuing patients from isolation, anxiety, terror, and loneliness. Most nurses respond really well to this (comparison).

RNJ: *You've said that doctors, politicians, journalists, health-care administers and the public also need to read this book. Why?*

SG: These are the people who make it possible or impossible for nurses to do their work. Nurses can't do their work unless they have adequate resources, and that requires money. Getting that (money) is a political problem. I don't think resources, respect and recognition is awarded to nurses. I don't think nurses are given enough authority in their institutions and in the health-care system.

RNJ: *One clear message emerges from your book: nurses must change the way they use their voice if they want to see change. Is that message as important today as it was when you first wrote* From Silence to Voice: What Nurses Know and Must Communicate to the Public*?*

SG: Nurses always have to explain why they're doing what they're doing. I think the virtue script in nursing has to be overcome. Nurses have to focus on their knowledge and their skills as opposed to only how kind, caring, holistic and compassionate they are. You can plunk a kind, compassionate person off the street and put them in a hospital and they'll kill patients. If kindness and compassion don't come along with competence, the patient is in trouble. I don't think (the virtue script) makes a compelling argument to bottom-line health-care administrators. Emphasizing nursing as a noble profession is simply not going to convince people as effectively as using the data to show that nursing saves lives, prevents suffering and saves money.

RNJ: *You've suggested the health-care system should look to the airline industry for guidance on developing good communication practices. Explain.*

SG: One of the things I stress a lot in my book is the problem of nurse-physician communication. When there's a problem, it is often because there's no team communication and negotiation. The airline industry around the world understands that crashes are often a result of poor communication. They instituted required team communication and negotiation training that is done at orientation and repeated every year. If a flight attendant has information about a problem, the pilot has been taught to listen. The flight attendant has been taught how to convey information effectively. It's really transformed relationships between cockpit and crew. A captain doesn't just take off without having asked a flight attendant their concerns. Imagine moving that model into health care.

RNJ: *You say hospitals execute cost-cutting on the backs of nurses and patient care. Some might suggest this is nothing new. Why does this trend persist, and how can nurses help reverse it?*

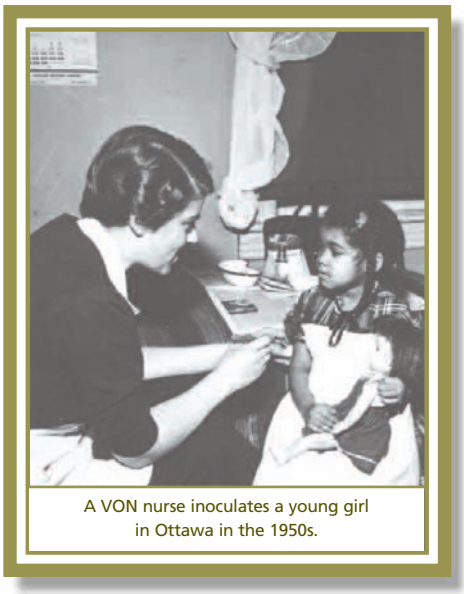
SG: People think nurses are nice and they don't understand that nurses are critical to whether they live or die. If you lay off a nurse to save $40,000 and then you pick up three bed sores that cost $70,000 each, you haven't saved $40,000; you've just spent another $170,000. There are many nursing groups that are putting a cost to what nurses do, but a lot of individual nurses don't do that. I think nurses have to be armed with data on the patient care and financial consequences of basic nursing activities, like helping a patient cough. If you don't help a patient cough, they get pneumonia and they have to be admitted to ICU. How much does that cost?

RNJ: *Your book describes a 'mission impossible' system in which nurses are in chronic stress response. What's the impact and what's the answer?*

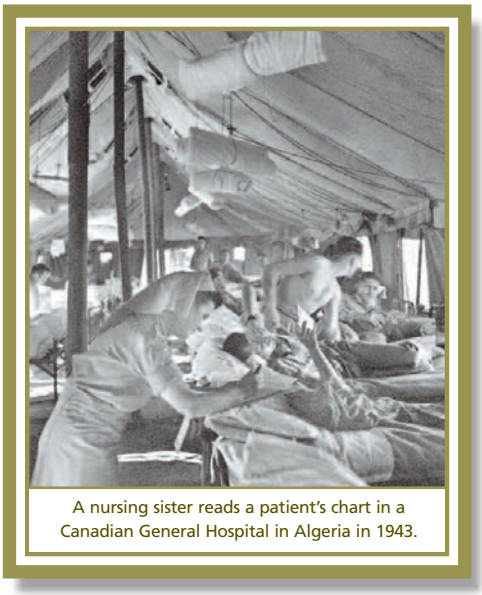
SG: I really wanted to find out about stress because nurses are asked to be empathic under the most horrible circumstances, and are expected to produce empathy like turning on and off the water in a faucet. It's very difficult to produce empathy and attention when you're in chronic stress response because your body is flooded with stress hormones. When you're paying attention to something, small areas of the cortex fire cells. But when you're in stress response, you can't get that kind of focused attention because all of the cells are firing. Nurses need to say 'you're putting us in situations where we can't function.' To produce that empathic attention you have to cut down on the fatigue, cut down on the stress, and provide adequate working conditions. **RN**

by **Anne Gilchrist**

Student and graduate nurse at a training school in St. Catharine's in 1901.



A VON nurse inoculates a young girl in Ottawa in the 1950s.



A nursing sister reads a patient's chart in a Canadian General Hospital in Algeria in 1943.

Nursing exhibit elicits pride, awe

Dr. Victor Rabinovitch, president and CEO of the Canadian Museum of Civilization (CMC), may not be a nurse, but he recognizes the importance of the role in our health-care system: "From life's start to life's end, there is always a nurse," he says. That's why the CMC is telling the story of nursing in Canada – from its beginnings in the 17th century, through the hardships and isolation of nurses past and present, to the increasing modernization of health care to contemporary issues and concerns about nursing's future.

A Caring Profession: Centuries of Nursing in Canada is an extensive collection of nursing artifacts on display at the museum until Sept. 4, 2006. The exhibit includes vintage films, historic photos and interactive presentations by present-day nurses who have taken time out to volunteer and share their experiences with visitors.

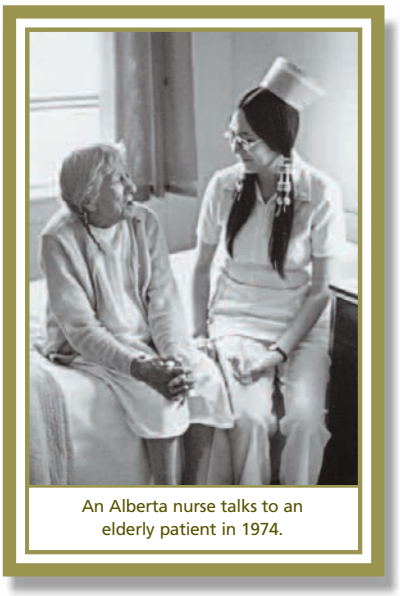
RNAO member Anne Gilchrist visited the exhibition in July, and provides an RN's perspective on a collection that the CMC describes as "the most extensive exhibition ever on the impact of nursing on the lives of Canadians."

Pride, awe empower nurses visiting historical exhibition

I had many reasons to be proud when I emerged after two-and-a-half hours at the Canadian Museum of Civilization's inspiring exhibition, *A Caring Profession: Centuries of Nursing in Canada*. Proud that nursing sisters were the first Canadian women to vote in a federal election in 1917. Proud that they were the first females in the world to achieve the rank of military officer. And proud that the first French language nursing degree program in the world is here in Canada at the University of Montreal.

At the entrance to the exhibit, I was greeted by life-size pictures of Jeanne Mance and Florence Nightingale, each representing the beginning of the two streams of nursing in Canada: the British secular movement and the French religious movement. The exhibition continued through an interactive spiral layout, exploring the history of nurses in the hospital, at the bedside, in the home, in the community, on the frontier, on the battlefield, on campus and on the picket line.

There are hundreds of interesting artifacts on display, including old apothecary jars, a nursing lantern, old nursing uniforms, various medical instruments, transportation equipment used by outpost nurses (skis, snowshoes, and a railway speeder), a maternity kit (or 'stork bag' as it was known in the 1920s), and a genuine iron lung used before modern respirators. It is impressive to contemplate how much progress has been made



An Alberta nurse talks to an elderly patient in 1974.

in our health-care system over the last 100 years. Consider the relative comfort of the modern respirator as compared to the 'iron lung' of the past, also known as the 'steel coffin.' The exhibit also made me realize some things have not changed much at all. The breast pump from the early 1900s looks a lot like the ones used today.

My visit to *A Caring Profession* gave me the opportunity to learn more about some outstanding Canadian nurses – past and present. Among the nurses whose stories are told: Jeanne Mance; Marie Angelique Viger; and Myra Grimsley Bennett. VON nurses, aboriginal midwives, military nurses, and a modern-day street nurse are also featured.

Throughout the exhibition, I was moved by the unwavering courage and commitment of nurses over the years. Nurses' primary concern has always been for the patient and their family. In the worst conditions, and sometimes at the risk of personal injury or death, nurses continued to always put the patient first. Nora Livingston, Superintendant of the Montreal General Hospital in 1891, is quoted in the exhibit as saying: "Nurse – the patient – always the patient first!" This is one of many quotes featured in the exhibition, each as relevant today as they were when they were first spoken.

My visit to the Canadian Museum of Civilization reminded me that some things have also changed over the past century, many of them for the better. For instance, one no longer has to be a white female to become a nurse. A past registrar of RNAO turned down an applicant to nursing based on race alone. Her letter from 1940 is on display: "There would no doubt be many protests from patients and doctors if colored nurses were introduced into the wards." Since then, the profession has certainly gained immeasurably from the input of all nurses, regardless of race or gender.

My visit also reminded me that life as a nursing student was a little different in the past. I enjoyed reading some handwritten excerpts in a student's notebook from 1920: "Qualifications of a nurse. #1. Courtesy…is defined by showing a well-bred consideration for others founded on kindliness and when met with irritation, fault finding and unjust criticism, remember the gentle answer that turneth away wrath."

It is reassuring to know that nurses no longer "remember the gentle answer" when met with irritation in today's health-care system. Also, nurses no longer have to stand when a physician enters the room. Instead, we are engaged in discussions with physicians, with politicians, and with fellow researchers.

This is an excellent exhibit and well worth a visit.

My only criticism is that nursing research was invisible. What about the first peer reviewed Canadian journal? What about Canada's contribution to nursing research? Two nursing colleagues to whom I spoke after touring the exhibit suggested it should have been larger and more comprehensive; they simply wanted to see more of a good thing.

To finish off the exhibit, visitors find themselves in the middle of an interactive nursing station where they can meet a volunteer nurse or write some reflections for the bulletin board. I enjoyed reading the messages from previous visitors, which included messages saying: "I walked around for two hours feeling proud to be a nurse," and "I am so honoured to be part of such a noble and caring profession!" Another wrote: "Our history is so rich that it is uplifting in these troubled times."

My favorite message was written in a child's handwriting: "Nurses are so COOL!" **RN**

ANNE GILCHRIST, RN, MSc(A), IS LEARNING RESOURCES CONSULTANT IN NURSING PROFESSIONAL PRACTICE AT THE OTTAWA HOSPITAL.

RN 'shows' the story of military nurses

RNAO member and nurse researcher Cynthia Toman was invited by CMC to be the guest curator for the military nursing section of its exhibition. She shares the challenges and rewards of this experience.

The Canadian War Museum (CWM) has a collection of artifacts, documents, and artwork on military nursing. It acquired additional material from the Nursing Sisters Association of Canada and the Canadian Nurses Association in 1999. Having recently completed doctoral research on the Second World War Canadian military nurses, the CWM invited me to survey and assess its military nursing collection. This project led to the further opportunity to guest curate for the military nursing section – a rewarding yet challenging experience.

The first challenge was to reduce the traditional reliance on written text to communicate research findings. With a quota of only 2,000 words to cover 120 years of military nursing history, I sought to 'show' more and 'tell' less. I developed themes and sub-themes through the precise selection and placement of material.

The second challenge was to develop effective strategies for communicating to a broad audience, which includes a wide range of demographic, social and cultural characteristics. I sought to draw visitors into the nursing story through a range of strategies, artefacts, and activities with which they might connect.

I was particularly touched by two incidents which I observed when the exhibit opened. One was a Second World War veteran who wept in front of one display. The second was a toddler with a headset on her ears, straining to look up at the video image of her relative talking about military nursing.

These visitors, among others who left hand-written notes, illustrate that nursing touches everyone's life.

CYNTHIA TOMAN, RN, PhD, IS ASSISTANT PROFESSOR AT THE UNIVERSITY OF OTTAWA AND ASSOCIATE DIRECTOR OF THE AMS NURSING HISTORY RESEARCH UNIT.

by **Ann Tourangeau** and **Lisa Cranley**

Survey measures nurse responses to work

The Ontario Nurse Survey 2003 *was led by Ann Tourangeau, assistant professor in the University of Toronto's (U of T) Faculty of Nursing. Lisa Cranley is a doctoral student at U of T working on the project. The survey results to follow are an important step in understanding how nursing care and work environments affect patient outcomes. These findings can also be used to help hospitals develop strategies that modify work environments to improve outcomes.*

Registered nurses' responses to the *Ontario Nurse Survey 2003*

Between February and June 2003, Tourangeau and colleagues surveyed RNs and RPNs working in Ontario hospitals to understand work environments and nurse responses to work. *The Nurse Survey 2003* was the first phase of two studies examining determinants of hospital outcomes including mortality and hospital readmission. Despite nurses providing the majority of care to hospitalized patients, little focus has been placed on studying nursing-related determinants that influence these outcomes. Previously, Tourangeau developed a theory of determinants of mortality and hypothesized that as well as patients' own characteristics, many hospital characteristics affect patient mortality. This model is being tested and refined. Here we summarize some findings reported by RNs in the *Ontario Nurse Survey 2003*.


A. Tourangeau


L. Cranley

Who was surveyed?

RNs and RPNs who reported on their 2003 Ontario College of Nurses registration renewal forms that they primarily worked in medical, surgical, or critical care areas within Ontario teaching and community hospitals were invited to complete the survey. Of the 13,100 nurses sent surveys, completed surveys were received from 8,456 nurses working in 105 hospital sites. Of these, 6,725 worked as staff RNs, 88 as clinical nurse specialists or educators, and 43 as managers.

Surveys were mailed to nurses' homes between February and May 2003. In the nine-page survey, nurses were asked to describe their assessments of: care quality; career intentions; job-related feelings; nature of practice environments; job satisfaction; and overall health.

Respondents' clinical areas

The largest group of RNs reported working in critical care units (2,491). There were 1,651 respondents from medical units, 1,560 from surgical units, 632 from combined medical-surgical units, and 251 who worked across multiple units.

Brief profile of RN respondents

The average age of RNs was 42.8 years. Overall, 60 per cent reported working full-time and 75 per cent reported regularly working 12-hour shifts.

RNs reported having an average of 8.4 years experience on their clinical units but this varied by hospital type. Nurses working in smaller community hospitals reported having the most experience (9.4 years) and nurses in large community hospitals reported having the least experience (7.9 years).

Evaluations of work environments and responses to these environments

RNs rated their overall level of job satisfaction as 'a little satisfied.' A total of 71 per cent reported being either 'very satisfied' or 'a little satisfied' with their jobs and the remaining 29 per cent reported being 'a little dissatisfied' or 'very dissatisfied.'

Nurses were asked to evaluate their practice environments in terms of their control over staffing resources, relationships among nurses and physicians, nurse manager ability and leadership, participation in hospital affairs, and presence of structures and processes necessary for quality care. A composite practice environment score out of 100 per cent was developed. On average, RNs rated their professional practice environment at 48 per cent.

Respondents were asked to rate their emotional exhaustion. Overall, nurses reported being moderately emotionally exhausted. The most emotionally exhausted nurses worked in large community hospitals and least emotionally exhausted worked in teaching hospitals. Nurses working in critical care areas reported being less emotionally exhausted than nurses working in other areas.

Nurses were asked to rate their overall health on a scale of one (poor) to five (excellent). The most common response by 38 per cent was rated as four (very good) and 61 per cent rated their health as excellent or very good. Eleven per cent rated their health as poor or fair.

Implications for nursing practice

Findings can be used to develop strategies that modify work environments to improve outcomes. When we examined survey findings, it became clear that more focus should be placed on building work environments that promote best patient, organizational, and nurse outcomes. **RN**

We wish to thank nurses who participated in the survey. For information about these studies, please visit http://www.nursing.utoronto.ca/atourangeau/.

ANN TOURANGEAU, RN, PhD, IS AN ASSISTANT PROFESSOR IN UNIVERSITY OF TORONTO'S (U OF T) FACULTY OF NURSING, AND A CAREER SCIENTIST FOR MOHLTC. LISA CRANLEY, RN, MN, IS A DOCTORAL STUDENT IN THE FACULTY OF NURSING AT U OF T.

Policy at Work

Online letters pour in from members supporting universal, single-tier health care

In an impressive show of support, more than 140 RNs responded within 24 hours to an RNAO July 27 action alert calling for letters to Ontario Premier Dalton McGuinty, urging him to rally fellow premiers attending the August Council of the Federation meeting in Banff to recommit to universal single-tier health care (see excerpts below).

This unprecedented response shows the unwavering commitment of registered nurses to ensuring a parallel, private health-care system does not threaten medicare.

The action alert was coupled with RNAO's vocal opposition to a Supreme Court decision on June 9 to allow private health insurance in Quebec – a decision the Quebec government has since been granted a suspension on for one year. Stemming from the claim of a Quebec man and his physician that an inability to purchase private health insurance constituted a violation of the guarantees of life and security under the Quebec and Canadian Charters of Rights and Freedoms, the decision poses a significant risk to a universal, single tier health-care system in Canada.

RNAO sent a letter to Premier McGuinty on July 21st urging him to place this issue front and centre on the agenda for the premiers' meeting in August. RNAO warned that the Council's silence on this issue will send a strong signal of implicit support to proponents of two-tier health care, many of whom stand to make millions from more privatized health care. RNAO's letter was sited by *Toronto Star* journalist Ian Urquart on August 11.

To read the letter to the Premier, view the action alert, or to add your voice to at least 140 others who have sent letters to Premier McGuinty and Minister Smitherman, visit www.rnao.org and click on Health and Nursing Policy.

Nurses tell Premier McGuinty and Minister Smitherman what they think of two tier health care

"I have many friends and acquaintances from the U.S. who are envious of Canada's health-care system. They cannot understand why we would try to pattern our system after other systems that have been shown to be inferior."
Betty Rowley, RN, North Bay

"Nurses and other health-care professionals base our practices on evidence. Yet, when something as important as medicare is challenged; countless others in health-care disciplines, economics, business administration, and health administration seem to ignore the evidence or interpret findings to discount the effectiveness of the system. Romanow asked people to bring evidence forward to show that another system would provide better results, however, none were brought forward."
Bonnie Hall, RN, Kemptville

"Poverty represents the greatest threat to health. I fear that a two tier health-care system will worsen the magnitude already felt by poverty as the most influential and negative social determinant of health. Please maintain our publicly funded health-care system in Canada. It is necessary as we all work towards the World Health Organization's mandate, "Health for All."
Janet Lovegrove, RN, Simcoe

"I have witnessed first hand, the 'cherry-picking' of patients for private interventions and surgeries. My husband and I have chosen to live in Canada despite the economic benefits available to us in the U.S. We chose Ontario and Canada because of universal health care and other social reforms we believe in. Don't take away one of the major reasons I am proud to be a Canadian."
Patti Staples, RN, Kingston

"With the addition of private health care there are not suddenly more doctors or nurses, which means they have to choose."
Julie Jarvis, RN, Uxbridge

"Until you increase the number of providers, the line ups will persist in the public sector but patients will be treated unequally. There will be more safety issues than we already have."
Margaret McGuire, RN, Guelph

RNAO provides input on regulatory issues for nursing

The Health Professions Regulatory Advisory Council (HPRAC) is a seven-member provincial board appointed by the Lieutenant Governor to provide independent policy advice to Ontario's Minister of Health George Smitherman.

RNAO, along with other stakeholders (i.e. the public, interest groups, health professionals, health professional regulatory colleges and associations), is providing input to the Council on matters relating to the regulation of health professions in Ontario. Some of the issues include: whether to regulate or de-regulate health professions; amendments to the Regulated Health Professions Act (RHPA); and matters concerning quality assurance, complaints, discipline, and patient relations programs of regulatory bodies.

RNAO will participate in a two-day consultation with HPRAC in October, offering recommendations and providing its perspective on issues as they relate to registered nurses and their patients.

For information about HPRAC, visit http://www.hprac.org. **RN**

Calendar

September

September 29-30
ELDER HEALTH, ELDER CARE
4th Annual International Conference,
Hilton Suites Toronto/
Markham Conference
Centre and Spa
Markham, Ontario

October

October 6
FIGHT OR FLIGHT: PROFESSIONAL SOLUTIONS TO CONFLICT IN THE WORKPLACE
Holiday Inn,
Sault Ste. Marie, Ontario

October 13, 14, 17, 18, 19
HOW TO DESIGN EFFECTIVE EDUCATION PROGRAMS
(SOLD OUT)
RNAO/OHA Joint Program
RNAO Home Office
Toronto, Ontario

October 20
ETHICS FOR NURSES
REGIONAL WORKSHOP
Days Inn and Convention
Centre, Kingston

October 28
PEDIATRIC HEALTH CARE:
CHILD FIRST, PATIENT SECOND
(CONFERENCE)
89 Chestnut Residence
Toronto, Ontario

November

November 11-12
ANNUAL NURSE
PRACTITIONER CONFERENCE
Toronto/Markham
Conference Centre and Spa
Markham, Ontario

November 17-18
HEALTHY WORKPLACES
IN ACTION
5th Annual International Conference
Hilton Suites Toronto/
Markham Conference
Centre and Spa
Markham, Ontario

December

December 6
INTERNET SAVVY FOR NURSES
Regional Workshop, Toronto, Ontario

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

Unless otherwise noted, please contact Carrie Scott at RNAO's Centre for Professional Nursing Excellence at cscott@rnao.org or 416-599-1925 / 1-800-268-7199, ext. 227 for further information.

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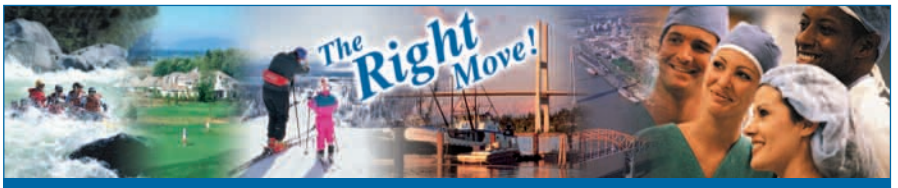
Email mgtprog@mcmaster.ca
Internet www.fhs.mcmaster.ca/nursing/distance/distance.htm
Programs starting every January, April & September



imagine
THE POSSIBILITIES!

FRASER HEALTH in British Columbia is a recognized leader in integrated health care, research into Population Health and exploration of more effective ways of delivering health services. Our dynamic workplace includes 12 acute care hospitals, public health, mental health and continuing care services. Fraser Health covers an area of British Columbia stretching from Burnaby to White Rock to Hope and serves more than 1.4 million residents.

Dare to dream. Join our 23,000 employees and 2,000 physicians in our pursuit of **Better health, Best in health care**, for our more than 1.4 million residents. Begin living the possibilities.

We currently have the following regular full-time and part-time opportunities available for **Registered Nurses:**

- **EMERGENCY**
- **CRITICAL CARE/INTENSIVE CARE/CARDIAC SURGERY ICU**
- **MATERNITY/SPECIAL CARE NURSERY**
- **NEUROSCIENCES**
- **OPERATING ROOM**
- **PACU**
  Strong critical care skills and experience working in a surgical environment required.
- **SURGICAL**
  Minimum of 3 years' experience required.
- **MEDICAL**
- **PSYCHIATRY**
- **SUBACUTE**

We also have the following managerial and advanced nursing practice leadership opportunities:

- **MANAGER, HEALTH SERVICES**
  Perioperative Programs (Operations & Systems), Royal Columbian Hospital, New Westminster
  Neonatology & Paediatric Services, Royal Columbian Hospital, New Westminster
  Residential Care, Peace Arch Hospital, White Rock
  Surgical Programs, Peace Arch Hospital, White Rock
- **CLINICAL RESOURCE NURSE**
  Hospice Palliative Care, Surrey Memorial Hospital
- **CLINICAL NURSE SPECIALIST**
- **CLINICAL NURSE EDUCATOR**
  Burnaby Mental Health
- **SITE LEADERS**
  Various locations
- **SHIFT COORDINATORS**
  Various locations

Clinical laddering education opportunities are available. Relocation allowance may be available. Opportunities for Specialty Education may also be available.

Please visit our website at **www.fraserhealth.ca** for a detailed listing of these and other positions and explore the opportunities available to you. Please contact us toll free at 1-866-837-7099 for more information.

fraserhealth
Better health. Best in health care.

www.fraserhealth.ca

NURSING EDUCATION INITIATIVE

A new funding cycle has been approved by the MOHLTC. For pertinent deadline information or to obtain a copy of the application form please **visit the RNAO Web site 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
e-mail Meagan Wright and Iris McCormack at **educationfunding@rnao.org**.

CALL FOR NOMINATIONS 2006 – 2008

RNAO BOARD OF DIRECTORS & COMMITTEES

As your professional association, RNAO is committed to speaking out for health, speaking out for nursing. To be even more effective in this regard, we need your involvement and your voice. RNAO is seeking nominees for:

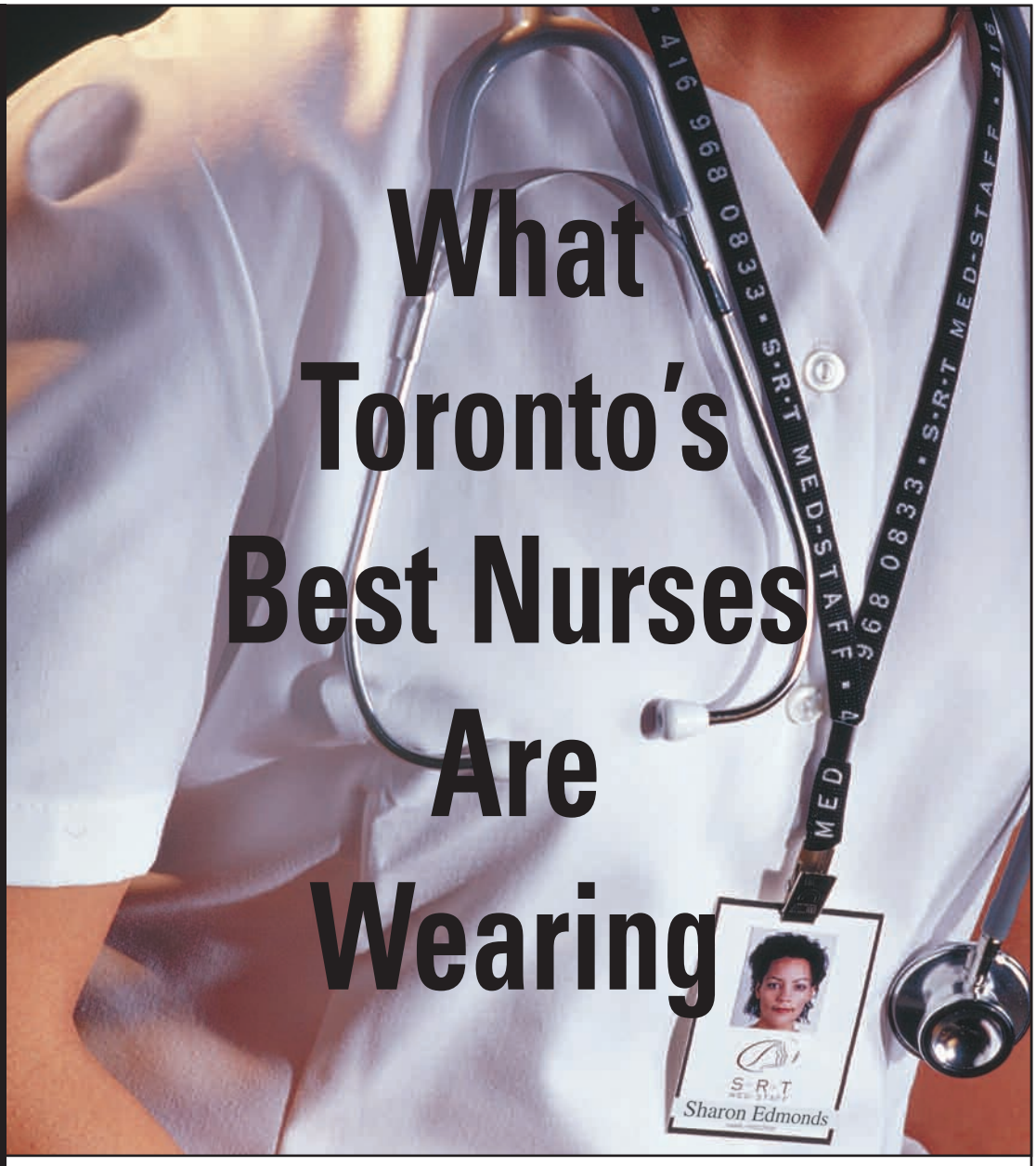
- Members at Large,
- Provincial Resolutions Committee, and
- Provincial Nominations Committee

By becoming a member of RNAO, you have the opportunity to influence provincial and national nursing health-care policy, discuss and share common challenges related to nursing, nurses and health care, and network with numerous health professionals dedicated to improving the health and well-being of Ontarians.

Being an RNAO board or committee member is an extremely rewarding and energizing experience. You will broaden your knowledge of nursing and healthy policy, improve your advocacy skills, participate in the long-term planning for the association, act as a professional resource to members and staff, and improve your leadership skills.

The nomination forms will be available on RNAO's Web site in September 2005. If you require further information, please contact Heather Terrence, 416-599-1925 / 1-800-268-7199, ext. 208 or hterrence@rnao.org.

Deadline for nominations: Monday, January 30, 2006 by 5:00 p.m.



What Toronto's Best Nurses Are Wearing

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MED-STAFF

S·R·T Med-Staff is a trusted leader in the healthcare community with a reputation for excellence in quality of care. In a recent survey of Toronto's RN's & RPN's, S·R·T Med-Staff ranked #1* in every category: The *most variety* of shifts, the *highest pay rates*, the *best overall agency* to work for and the *best quality nurses*. That's why our staff are in such high demand. Hospitals know they can trust S·R·T Med-Staff personnel to provide an exceptional level of care.

If you want to work with the best, make S·R·T Med-Staff your first choice. For a personal interview, please call us at 416 968 0833 or 1 800 650 2297.

e-mail: admin@srtmedstaff.com

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