MEMOIRS of NURSING

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Editor’s Note

Surprise moments on a humdrum highway

While carpooling from the cottage with my parents a few weeks ago, we were engaged in the usual road trip banter when my father mentioned that he’d been speaking with a former work acquaintance a few days before. It was an interesting enough comment in passing, but it meant a lot more when he told me the man had asked how I was doing. I was confused. Why would he ask about me? Had I met him?

Turns out I had, many years ago when I interviewed him for a story I wrote about Hurricane Hazel and its impact on Richmond Hill residents. I was a reporter for a York Region newspaper at the time and he had an interesting tale to tell about one of Ontario’s most famous—if not infamous—weather events of the 20th century. I felt bad about forgetting our conversation, but admitted to my parents that any recollection of his story would be about as easy to conjure up as the basics of calculus that I learned back in high school.

I have no doubt this man’s experience was compelling and tragic. This haphazard conversation in the car many years later, however, made it obvious to me that his tale wasn’t the sort that would embed itself into my brain for future reference. During the silence of the following few hours heading south to Toronto, I started thinking about the hundreds of people I’ve interviewed throughout my career, and who I might select as my most memorable. Forget crosswords and calls of ‘I spy’ to keep the mind occupied on a humdrum highway. This was a real brain teaser.

As you flip through this summer issue of the magazine, you will read about the memories, meaningful encounters, and moving professional moments that have embedded themselves in the minds of members responding to our Nursing Week call for stories. They too are compelling and tragic. And they are recalled with clarity and compassion. I laughed and I cried when I read them, and I commend the nurses who shared their stories for reflecting back on their experiences and telling us what nursing truly means to them.

As for me, I haven’t come up with my most memorable yet. But I’m working on it.

Kimberley Kearsy
Managing Editor
Provincial footprints in a national landscape

We have celebrated two very special birthdays: CNA’s 100th and Canada’s 141st since last I had the opportunity to ‘speak’ with you through this Journal.

Birthdays are a cause for celebration and I can confirm that the CNA centennial in Ottawa in June was a very special time for all who attended.

Birthdays are also a time for reflection, on where we have been and where we are going. The many events at the CNA board and annual general meetings this summer were special, but they also provided an opportunity to conduct substantial business. I want to share with you news about where we are headed, and acknowledge the tremendous success you – our membership – has had in bringing our shared agenda to the national level.

First of all, you may recall ongoing discussions at the provincial level about the urgent need for a national voice to speak out in support of Medicare. This is the first of RNAO’s strategic directions to “…influence public policy that strengthens Medicare and impacts on the determinants of health.”

This direction shapes much of what I – in company with the board and staff of RNAO – do on behalf of the public and nurses. This strategic direction mandates that we speak out on the issue of Medicare, calling to account both the federal role in enforcing the legislation that protects our provincially delivered health-care services, and the provincial government in ensuring the letter and spirit of that legislation is reflected in the funding and delivery of those services.

There’s no question that Medicare is under growing threat in many parts of this country. I very strongly believe that there is a critical need to rally people federally, and in all provinces and territories, to speak out for the expansion, not the contraction, of our current Medicare system.

I am glad to share with you that the movement to speak out for Medicare is about to grow in both number and volume. At the CNA board meeting, the motion to establish Nurses for Medicare under the CNA umbrella, a motion submitted by RNAO, was passed. I look forward to working with our colleagues on the CNA board to bring this most important vision to life, and create an activist agenda to protect and strengthen publicly funded and not-for-profit health services.

This is a significant step forward, but it isn’t the only step. RNAO presented other motions to CNA for discussion and vote at the meetings. I am delighted to tell you that all of those motions passed, and passed easily. Each one spoke directly to our mandate of Speaking out for health. Speaking out for nursing. The social and environmental determinants of health – the determinants that profoundly shape the health of our communities – are evident in our submissions to CNA. The support of our colleagues across the country is evident in the passing of each motion. And your commitment, as RNAO members, to the development of these submissions speaks to the clear recognition you have for our national role. The passage of these is just one more marker of your success on that national stage.

With the passage of the resolutions, CNA must now turn its attention to operationalizing all of the advice given by the membership on the floor of the AGM. The work ahead will address not only the resolutions themselves, but also the substantive discussion related to emerging health-care issues such as the threat to self-regulation of nurses and the increasing reliance, in some parts of our country, on international recruitment to meet health human resource shortfalls. Both of these challenges will require hard work on our part as we advocate for strengthened, not diminished, self-regulation, and for sustainable, home-grown solutions for our shortages.

In addition to the ‘business’ of the national board, there were some pleasant announcements at this year’s meeting. The national nursing community elected Judith Shamian, a former RNAO president and a nurse leader well known to all of us in Ontario (and, indeed, across Canada and throughout the world) as CNA’s president-elect. She will work with the new president, Kaaren Neufeld, as CNA continues to move forward into its next 100 years.

I hope you have been reading this in a park, on a dock, in your garden or wherever it is that you find the joy of our Ontario summer. This all too fleeting season is one to be treasured, savoured and remembered during those longer, colder nights of winter. If you are now on holiday, enjoy. If you have been on holiday, welcome back, renewed and refreshed. And if you have yet to go, I wish you blue skies and warm weather.

See you in September. RN

WENDY FUCILE, RN, BScN, MPA, CHE, IS PRESIDENT OF RNAO.
Building on our strength with Ontario’s new health minister

It was only a few days after David Caplan was sworn in as Ontario’s new health minister in June that I received a call from him. It wasn’t the first time I’d spoken with the former infrastructure minister. In fact, RNAO has an already well-established relationship with the Toronto MPP.

While in opposition as housing critic, he introduced the Fair Rent Increases Act to protect tenants, and supported a national housing strategy. Caplan was also one of the ministers responsible for the $602 million Affordable Housing Agreement signed in 2005 with the federal government, which re-engaged governments in this crucial area of work. RNAO applauds Minister Caplan’s support and leadership on these issues.

It will be important to see the same leadership on the crucial issue of publicly funded, not-for-profit delivered health care. Minister Caplan’s adoption of, and staunch support for, private/public partnerships to build hospital infrastructure in Ontario is a direct threat to Medicare. During his tenure as minister of public infrastructure, we met with him to discuss our opposition. In our most recent conversation in June, I reiterated the nursing community’s unwavering commitment to public Medicare.

Minister Caplan said to me that he is tremendously honoured to receive the Premier’s trust and appointment as minister of health. He is excited about working with RNAO and developing a closer partnership with nurses. I congratulated him, and shared our commitment to the health of all Ontarians, and our strong desire for a close working relationship with him. To build this relationship, I said it is imperative that nurses see the choices he makes on specific policies.

These include deliverables on: funding and opening 25 additional nurse-practitioner led clinics, promised by the Premier. Three are slated for 2008 and Minister Caplan confirmed with me that these are already in the works. He must also deliver on all other platform and Throne Speech commitments, including: 9,000 additional nurses (we expect 6,500 of these to be RNs); achieving 70 per cent full-time employment for all working nurses; guaranteed employment for new nursing graduates (we expect it to be full-time employment); and investments in healthy work environment initiatives that will keep nurses and serve to attract additional ones into the profession.

I conveyed that we will work hard with him to deliver on all these commitments. I added that RNAO and nurses will be his biggest champions for initiatives that serve to strengthen Medicare, and would fiercely oppose those that weaken it.

My conversation with Minister Caplan brought back memories of his predecessor George Smitherman, who visited us the day after taking office. I recall Minister Smitherman’s insightful question on that visit. He asked what his first priority should be as a minister determined to improve health care in Ontario. My answer was decisive: “Balance the power base between the hospital sector and all other sectors – and between medicine and all other health professions – and you will be well on your way to meaningful and positive health reforms.” That meeting set the tone for the five years that followed. Minister Smitherman turned to RNAO and to nurses many times throughout his term to get our views on various health-care issues.

Smitherman’s attention to the needs of nurses and his recognition of the impact of the nursing workforce on health care was intense, and we worked on many initiatives that have strengthened the profession and our ability to serve Ontarians. We wish him well in his new ministerial appointment, and we know that our paths will continue to cross.

As we start working closely with Minister Caplan, my advice doesn’t change. The McGuinty platform and Throne Speech set a clear path for vital initiatives to boost the profession and serve the public. For that, it is essential Minister Caplan move quickly with the legislative changes that will allow existing and new extended class RNs to fully serve the public.

He must also provide assurances of the government’s continued work to strengthen home care by ending competitive bidding; and improve elder care by setting – in law – a minimum of 3.5 hours of daily nursing care in all long-term care facilities.

RNAO also expects support from the minister on key issues that affect health outcomes, but which are not directly under his responsibility. I am referring to social and environmental determinants of health. We want him to actively participate in the government’s poverty reduction plan, advocating for clear and ambitious targets. We also want him to support tough regulations for the new provincial ban on cosmetic pesticides; and to move swiftly to reduce toxins and carcinogens in the food chain and in the environment. These are vital determinants of health.

Our ‘new beginning’ with Minister Caplan is sure to be a mix of fun and challenge. Above all, I know we will build a strong and productive relationship together. The public and nurses deserve no less.

DORIS GRINSPUN, RN, MSN, PhD (CAND), O.Ont, is EXECUTIVE DIRECTOR of RNAO.
RN helps grieving boomers cope

After her mother’s passing, Jane Galbraith transformed her thoughts into words to help fellow baby boomers deal with life after death. BY JILL SCARROW

The call Jane Galbraith had been dreading came at 1:00 a.m. during a January snowstorm. At the other end of the line was a palliative care nurse at the local hospital. Galbraith’s mother, who had been ill for some time, likely wouldn’t live to see the snow melt in the weeks ahead. Despite the slippery roads, Galbraith was determined to see her mother one last time. But as she pulled on her clothes, the phone rang again. This time, it was a doctor. He said her mother had died. As Galbraith hung up the phone, she felt completely alone.

A few months before that dark morning in 1993, Galbraith never imagined that her mother’s life was nearing its end. There were no clues the vibrant, active 71-year-old was ill until one night in early December, when she suddenly complained of tightness in her chest. In the following weeks, tests revealed she had cancer, and she suffered a stroke that left her without the ability to speak. It was a painful reality for the mother and daughter who spoke nearly every day.

After more than 20 years in home care, and with experience as a case manager helping palliative patients and working with local hospices, Galbraith thought she had a firm grasp on how families cope with death. She soon discovered she was wrong. Nothing in her nursing experience could have prepared her for her mother’s illness, or for the grieving process that followed.

“I realized I was underestimating the impact of it significantly,” she admits. “The first year after she died, I went to work. I walked. I talked. But it does seem like a fog.”

As the fog cleared in the years that followed, Galbraith began to think that if her nursing knowledge wasn’t enough to prepare her for her mom’s passing, her baby-boomer friends with no health-care background would be floored when their parents died. That’s why she began writing *Baby Boomers Face Grief: Survival and Recovery*. She now takes the book’s message around the province as she speaks to health-care workers and volunteers who deal with older adults and end-of-life issues. She talks about the cultural barriers surrounding death, and the toll the experience takes on people who feel they must go on as though nothing has changed.

What Galbraith calls the ‘stiff upper lip’ approach to death keeps many people from talking about their grief, and is entrenched in workplace policies that assume sadness stops after the funeral.

“I get angry at the way our society deals with it,” she says, noting that employers often provide only a few days of bereavement leave. “I started thinking we have to change the way we deal with this, or people are not going to have anyone to turn to because our society doesn’t let them talk about it.” Given the number of baby boomers who will likely face their parents’ deaths in the next few years, she suggests that it’s going to have a ripple effect on relationships and workplaces unless people have the resources to help them cope.

Galbraith explains in her book that people shouldn’t be surprised if rogue waves of emotion suddenly crash over them long after the funeral is over. One day, months after her mother’s death, her car phone rang. When she answered it and heard a colleague say hello, she suddenly burst into tears. Memories of her mother, who would often phone her, suddenly came flooding back.

Galbraith says she hopes her book will help people deal with those experiences. She suggests talking to friends and family, joining bereavement groups, chronicling feelings in a journal, or pursuing hobbies. For Galbraith, peace of mind came whenever she was around horses. She learned to ride the fall before her mother became ill, and says it’s a hobby she still turns to for solace.

“I found there were a lot of things that triggered thoughts of my mother. But when I was at the barn, it gave my brain a rest,” she says. “There was something calm and quieting about the horses, even when I fell off.”

The Burlington RN says she hopes anyone who reads the book will see they’re not alone if they’re overwhelmed by the death of someone close. That’s especially true for nurses who develop relationships with their patients and often feel a loss when they die. Galbraith says she’s come to understand how important it is for health-care organizations to have support systems in place, whether staff are grappling with grief professionally or personally. More than half of RNs are baby boomers, and as they face this stage in life, they should be able to erase some of the taboo around talking about the emotional turmoil that follows a death.

“I hope people will be surrounded by friends and co-workers in a society where they can share their feelings, and not feel shut down if they try to express themselves.”

JILL SCARROW IS STAFF WRITER AT RNAO.

Registered Nurse Journal
Nurses want pesticide law amended

In mid June, Ontario passed legislation banning the use and sale of cosmetic pesticides. Nurses are dismayed that the law doesn’t go far enough to protect public health (see page 25 for more information). The legislation was supposed to protect people, especially children, from poisonous chemicals. But “...what the province’s legislation actually means is that municipalities will be stripped of their tough municipal bylaws to protect people,” said RNAO President Wendy Fucile (June 19, exchangeMagazine.com). While nurses recognize the law is an improvement over the current situation, they also believe the government should restore the essential municipal power as quickly as possible and treat municipalities as full partners in public health, Fucile added.

Handwashing crackdown to control hospital infections

By next spring, the Ministry of Health expects to make the results of a new “hand hygiene compliance” report available online for the public. But what this means for hospitals is still unclear. The single most effective way to control the spread of deadly, hospital-borne infections (such as C. difficile) is to make sure hospital staff wash their hands, the ministry says. With hundreds of cases of the infection and related deaths throughout Ontario, handwashing is going from encouraged practice to enforced rule. RNAO member Sandra Hett is chief of patient services at Kitchener’s St. Mary’s General Hospital. For some hospitals, the new rules may require changes to the way the rates of infection are recorded. “Until we see all of the definitions and all of the timelines, it’s a bit hard to know what the implications will be for us,” she said. (May 29, Waterloo Region Record)

Nurses to ease ambulance off-load delays

On May 30, the McGuinty government dedicated $4.5 million to hire nurses to exclusively care for ambulance patients when ERs are backlogged. The nurses will stay with patients until a bed becomes available.
available. The goal is to free up paramedics, who in the past were not allowed to leave the hospital until their patients were admitted. RNAO member Winnie Doyle, co-chair of the Hamilton Emergency Services Network, which monitors off-load times in the ER, said the program’s success will depend on recruiting nurses during a shortage. “We are certainly willing to give this a try,” she said. (June 13, Hamilton Spectator)

RNs weigh in on latest nursing shortage data

Delegates at the Canadian Nurses Association national conference in Ottawa this summer learned that the gap between Canadian nursing graduates and demand stands at more than 2,500 nurses a year. “We know that the shortage will hit us between 2012 and 2016. We’re only four years away,” said RNAO member Ginette Lemire Rodger, chief nursing executive at the Ottawa Hospital (June 18, CanWest News Service, Canadian Press, Toronto Sun, BayToday.ca). Fellow RNAO members Ellen Rukholm and Kristen Woodend, also weighed in on the dilemma.

Rukholm, executive director of the Canadian Association of Schools of Nursing, said there just aren’t enough spots available in nursing schools, and space is especially needed for master’s and PhD-level students to produce future nursing professors. Woodend, director of the University of Ottawa’s School of Nursing, said students are interested in the field, but space is limited. There were 2,000 applications this year and only 400 spaces. The school is also short five or six faculty members. (June 18, CanWest News Service, Canadian Press, Toronto Sun, BayToday.ca)

Blood pressure pilot launches in First Nations communities

In June, the Heart and Stroke Foundation launched pilot programs in two Manitoulin Island First Nations communities — Whitefish River and Aundeck Omni Kaning. The programs, which aim to help people lower their blood pressure, include toolkits handed out to nurses, physicians and pharmacists. “We really want to look at determining how effective the toolkit is in making a difference,” said RNAO member Margaret Moy Lum-Kwong, director of the foundation’s high blood pressure strategy (May 22, Sudbury Star). With data collected during the pilot, Lum-Kwong will also assess the prevalence of hypertension in aboriginal communities. The foundation is launching similar programs at 11 other sites across Ontario, and will evaluate the success of the pilot in early 2010.

Nursing students raise awareness about violence against cab drivers

Two University of Western Ontario nursing students want to raise awareness about violence against cab drivers and how to prevent it with safety shields. In June, Jared Coyne and Adnan Ziendiem submitted a brief to London’s municipal council that was referred to an environment and transportation committee for review. In the brief, the RNAO members noted that Toronto introduced safety shields in 2001 as part of a comprehensive safety bylaw, cutting assaults against drivers by 35 per cent. “For each dollar spent on safety shields, $17 is saved on injury treatment and lost wages,” Ziendiem told the London Free Press (June 16), adding he is friends with many cab drivers and is upset with the increasing violence they face.

Wound care experts explore latest developments

In early June, RNs and other health-care professionals from around the world came to Toronto for the Third Congress of the World Union of Wound Healing Societies conference. The experts discussed a variety of issues, including pressure ulcers, treatment of acute wounds, burns, and ulcers resulting from diabetes. Risk assessment is the first step, said RN Heather McConnell, Associate Director of RNAO’s International Affairs and Best Practice Guidelines Program. Assessing a patient’s ability to recognize a pressure point, the extent to which skin is exposed to moisture, or a person’s activity level and nutrition status are all considered. “We all have a common interest in improving patient outcomes related to wound care,” she said. (June 6, OMNIway.com)

Blood pressure pilot launches

On June 16, RNAO member and diabetes educator Anna Brundage wrote a letter to the editor urging the public to actively check their blood sugar levels and talk to health-care providers about how to prevent diabetes.

Check your blood sugar

Toronto Sun

As a registered nurse who works as a diabetes educator, I applaud the Ministry of Health for making the prevention and management of diabetes a top priority. In my daily practice, I give my clients the information and support they need to manage their blood sugar levels and prevent the painful and devastating complications of diabetes. The ministry predicts 1.2 million people in the province will have the disease by the year 2010. Many cases of Type 2 diabetes can be prevented if people are made more aware of the importance of eating healthy foods and exercising regularly. A person can find out if they’re at risk of developing diabetes by having their blood sugar levels checked and talking to a nurse or other health-care professional.

Anna Brundage, R.N

Toronto, Ontario
Sudbury RNs appointed to LHIN board

Sudbury RNs Gisèle Guénard and Brenda Roseborough both have extensive experience delivering tailored health-care programs and services in their community. The two nurses, who were recently appointed to the North East LHIN Board of Directors, can now provide a new kind of service. Their appointments, effective through to January 2010 and May 2011, respectively, have left both feeling proud and excited to contribute to community health at the decision-making level. “It is an honour to be part of the North East LHIN governance team,” Guénard told the Mid-North Monitor (June 12). “I am looking forward to contributing to the health care of citizens (in) north east Ontario,” Roseborough added. RN

On May 31, RNAO Executive Director Doris Grinspun wrote a letter to the editor calling for the government to indefinitely end competitive bidding for home-care contracts.

Stop competitive bidding

Toronto Star

There is no doubt that our priority is to provide quality home care for those who need it. But we take issue with the suggestion that competition is good for the home-care sector. Competitive bidding is the antithesis of good patient care. It leads people to compete rather than to collaborate. We applaud the decision taken by the health minister earlier this year to place a moratorium on the process used to award these contracts. We urge him and the premier to end the practice of competitive bidding once and for all.

Doris Grinspun
Executive Director, RNAO

New nursing grads in London pose for a quick photo after writing their CNO qualifying exam in June. They were greeted by RNAO members and staff with an energy-boosting granola bar as congratulations for completing the eight-hour exam, and as a reminder that RNAO has lots to offer new grads. Thousands of bars were also handed out in Thunder Bay, Sudbury, Ottawa, Toronto and Hamilton.

RNAO member and Stirling public health nurse Donna Ferguson receives her Nurse of the Year award from Quinte Sunrise Rotary Club Vice President Gord Levertou. Ferguson was recognized at a Nursing Week banquet in the spring. She received the honour for demonstrating excellence in nursing and making a significant contribution to her community.

RNAO members Tina Robinson (right) and Barb Menard (left) invited the senior kindergarten class at Red Lake Madsen School in Red Lake, Ontario, to participate in a teddy bear clinic this spring. The kids brought their favourite plush toy from home and had help from the nurses to monitor both the toys’ and their own heart rates. They also assisted the nurses in fitting their toys with arm slings and eye patches.
Trade agreements: Do nurses care?

They should, especially if they are passionate about social and environmental determinants of health. Understanding the implications of the Trade, Investment and Labour Mobility Agreement (TILMA). by Ricardo Grinspun and Wendy Fucile

Trade agreements? Investment rules? U.S.-Canada relations? Inter-provincial relations? Nurses already have many challenging issues on their plate. Why concern themselves with these other technical and seemingly less relevant issues?

Reframing the question will help. Do nurses care about social and environmental determinants of health? Do they support creating secure jobs that pay a living wage, strengthening Medicare, enhancing social programs, eliminating poverty? Are they concerned about clean air and water, food safety, less exposure to dangerous chemicals?

Yes, to all.

Trade and investment agreements can fundamentally impact all of these determinants of health. In fact, critics of the Canada-U.S. Free Trade Agreement (1989) and the North American Free Trade Agreement (NAFTA) (1994) argue they have had a damaging effect on social and environmental health.

These same critics argue that trade and investment agreements empower transnational corporations to establish themselves, demanding that governments lower taxes, lower environmental standards and lower wages. Governments have responded through tax cuts for the wealthy that diminish fiscal resources, leading to cutbacks in government programs. We end up with a more unequal society. Poverty, climate change, urban sprawl, pollution, infrastructure gaps, and overall quality of life become afterthoughts.

At the same time they advocated for NAFTA, Canada’s biggest business organizations pushed for an extension of similar trade rules to inter-provincial activity. As a result, the Agreement on Internal Trade (AIT), signed by the federal government, provinces and territories, entered into force in 1995. A decade later, Alberta and BC signed – without public consultation – the much stronger Trade, Investment, and Labour Mobility Agreement (TILMA), which came into effect April 1, 2007. Calls have since gone out for other provinces and territories to join TILMA.

Touted as an innocent effort to eliminate provincial trade barriers, the reality of TILMA is quite different. The agreement requires provinces and, two years after enactment, their official agencies (i.e. hospitals, municipalities, public school boards, universities) to prove that the rules and regulations they enforce do not “restrict or impair” trade and investment (i.e. profits). And there are penalties for infringement: TILMA creates a mechanism for allowing private investors to sue for any rules and regulations that restrict or impair profit making.

In Peterborough, for example, community leaders showed foresight in enacting a ‘no cosmetic pesticides by-law’ ahead of many other jurisdictions. Were Ontario to join TILMA, a pesticide company in another province might be able to sue the City of Peterborough for up to $5 million to compensate from its losses due to this health measure. There is no limit on how many pesticide companies could sue for up to $5 million per claim, until the regulation is rescinded.

Similarly, if a provincial government increased the minimum number of hours of nursing care required per resident in a nursing home, that regulation might be liable for challenge by a for-profit business because there would be less profit as a result of improved conditions of care.

TILMA contains language that purports to protect the ability of governments to implement “social policy,” but healthy skepticism is called for since similar (and vague) language in other trade agreements has been ineffective in providing real protection.

So, where is Ontario in all this?

Big business has forcefully asked premiers to take TILMA national. Regrettably, Premier Dalton McGuinty and Canada’s other first ministers agreed to start moving in this direction – despite public opposition – at the Council of the Federation meeting in January 2008. McGuinty also announced late last year that Ontario and Quebec are starting to negotiate an inter-provincial agreement. Is this another TILMA? That is the concern, particularly given the drive to privatize Quebec’s health care and other public sectors.

Time is of the essence if we are to halt these harmful agendas. RNAO has issued an action alert and has written to McGuinty asking him to reject TILMA because it conflicts with core commitments of his government to advance democratic governance and the public good. The Council of Canadians website has valuable information on TILMA which has helped us in the writing of this article. Visit www.canadians.org (click your way to “deep integration”) to learn more and for ideas on how you can take action.

Please get involved. It is always a good time to enliven democracy through vigourous citizen mobilization.

Ricardo Grinspun, PhD, teaches economics at York University.

Wendy Fucile, RN, BScN, MPA, CHE, is president of RNAO.

Registered Nurse Journal 11
a simple shower

by Susan Ritchie

Like many nurses, I went into nursing to care for others. In my clinical practice, I worked on an acute medicine unit, which included palliative care. Taking care of palliative patients was not always easy, but I found it to be most rewarding.

One time in particular, probably not even two years into my career, I was taking care of a woman in her 50s who was in the end stages of breast cancer. She desperately wanted a shower. I knew this was not going to be easy, but it was really important to her. As I gathered supplies, I realized this was no simple shower.

I wrapped up the subcutaneous set in her arm that was connected to the pump delivering her pain medication. I wrapped up the subcutaneous sets in her legs where she was getting other medications, and covered her saline lock. I put her on portable oxygen and helped her onto a commode chair with her catheter drainage bag hooked on the side. To ensure her privacy and comfort, I wrapped her in a blanket. With the portable oxygen and pain pump slung over my shoulder, we were off to the shower room.

I helped her wash her smooth head with shampoo and applied sweet smelling body wash as she wished. Once finished, I dried her off and helped her back to her room where I unwrapped all the tubes, gave her dry oxygen tubing, helped her dress, and assisted her back to bed. I had never seen someone to whom a shower meant so much. The whole venture took an hour and wore her out for the rest of the day. I was so glad that I could help her with something that she felt was so important, and was probably the last shower she ever had.
I practised as a visiting nurse for about 10 years. This involved caring for patients facing decline and death and caring for their families and significant others, including spiritual care. I would like to share the gift of a treasured story.

I have faith in the sacredness embedded in our day-to-day existence. The sacred can be found in different ways. For me, it comes in the beauty and awe of the presence of a flower. I planted a rose bush at home and as it bloomed, the tiny pink flowers were given to the patients and families I visited that day.

At one time, I had the privilege to care for an elderly man we’ll call Mr. J. He was facing decline and death from cancer. I was connected to Mr. J and his family for many weeks in the spring and summer months.

Early one morning, Mr. J. passed away just prior to my arrival. His wife was in her kitchen praying to Saint Therese (’the little flower’) for a rose or the fragrance of a rose as a symbol of her husband’s safe passage. I entered the room bearing a perfect pink rose.

Mrs. J’s face was radiant as she tearfully brought the flower closer to draw in the sweet fragrance and she said “he sent me my flower.”

I believe my rose bush was blessed and that the roses I gave away each day evoked healing.

DURING NURSING WEEK 2008, RNAO invited members to share their nursing stories. RNs from across the province told us why they chose the profession and what they love most about what they do. Thank you for sharing your intimate tales of challenge, your proudest moments, and for telling us about patients who moved you. We know that every nurse has an incredible tale to tell, and we hope this small sampling of submissions will inspire you as much as it inspired us.

ILLUSTRATIONS BY JOHN WEBSTER
In 1960, when I was in my second year of nurses' training, I met my most memorable patient. Our psychiatry course included a one-month ‘affiliation’ at a hospital for mental illnesses. We had lectures by psychiatrists, psychologists and other staff. The rest of our shifts were to be spent with the patients. We were cautioned to always go in pairs to certain areas of the hospital. I found the locked doors and restraints in some areas very foreboding.

After reviewing the charts for diagnosis, treatments, medications and familiarizing ourselves with the symptoms of particular mental illnesses, we were to spend time observing patients. We socialized with them and joined in their activities such as crafts, music and exercises. We were to converse with them, assist them where necessary, and report back our findings to the class.

It was in the recreation area that I first met Joe, a handsome 19-year-old with gorgeous black curly hair. I tried to engage him in conversation but he communicated very little. He didn’t interact much with staff or fellow patients and wandered around a lot, often talking to himself.

His diagnosis was paranoid schizophrenia. Occasionally, he would dance with the students and appeared to like music.

The staff had prepared a Christmas concert and had included Joe on the program. His voice was spectacular as he gave a Pavarotti-like rendition of O Tannenbaum in English and German. The applause was loud and his parents were beaming.

Up to the time of the concert, I saw Joe – in the terminology commonly used at that time – as a ‘mental patient.’ After the performance, I saw him as a person of great talent with a mental illness. In the 35 years I spent nursing, I met many interesting patients, but Joe remains my most memorable.
nursing in God's country

by C O N N I E W O O D

Haliburton Highlands is a rugged stretch of forest and rock. Famous for glittering lakes, winter sports and fall colours, it attracts tourists year round. Some call it God's country. I call it home.

When I started my career here more than 30 years ago, the hospital was a small Red Cross outpost with eight beds. Now, our community has a new facility that has been praised by Ontario's Minister of Health as a model for integrated health care.

Years ago, when I drove down forgotten back roads delivering nursing care, I sometimes felt as if I was travelling back in time. I remember pulling up to one run-down farmhouse with a sagging porch. I was afraid of the dismal conditions I might see inside. Instead, I found a woman, bedridden with multiple sclerosis, who transformed punishing poverty into a loving family home by the sheer strength of her cheerfulness. Paralyzed and in constant pain, she glowed with good will and kindness. Although her home was isolated, it was the centre of her universe and it became a school of wisdom for me. She taught me that nursing is about building relationships. I learned that, when nurses empower patients and families to be partners in health care, strength of spirit and greater independence is the result.

This woman showed tremendous courage in raising her family; and I consider it a privilege to be part of a profession that helps people like her live full and productive lives, despite their health challenges.

Today, I am part of a dynamic team of professionals in a Family Health Team. I know the stories behind the faces I see in the waiting room. I remember their parents and their grandparents. We care for patients as if they are friends and family. In most cases, they are.

a baby’s curl

by S U B W E A T H E R B Y

My most rewarding experience happened the first year I was in nursing in a pediatric intensive care unit.

One day, I was assigned to a four-month-old who was an aborted SIDS. It was the first child born to a woman who had tried to conceive for years. As I entered the room, I saw the mother resting her head on the side of the crib, holding her baby's small hand. She spoke of the curl of hair that sat on top of her baby's head, and the little pouty lips she loved to kiss. Over the next few hours, I listened to the mom talk about her love for her baby, and the horrible moment she was found unresponsive in bed. She spoke of the curl of hair that sat on top of her baby's head, and the little pouty lips she loved to kiss. Over the next few hours, I listened to the mom talk about her love for her baby, and the horrible moment she was found unresponsive in bed. Unfortunately, the baby did not survive. I remember the pain in the mom's eyes. I asked her if she would like to hold her baby for a while. She was scared and unsure.

I bathed the baby and washed her hair with baby soap and shampoo. I wrapped the baby in a small pink sleeper and receiving blanket and, with a small bit of baby oil, I scooped her hair into a curl.

I remember walking into the room with the baby, and the mom immediately cried and said, “You remembered her curl.” For hours the mom and her family took turns rocking and singing to the child.

The next day, I went to work and saw something had arrived for me. It was a small glass globe with a floating yellow rose. The note said: “Thank you for giving me my baby back. You brought her to me, as I knew her, and the last few hours (we) had will always be cherished.”

Peggy, my extremely compassionate and skilled preceptor, came up to me, put her arm around me and said, “You made a difference. That is what nursing is all about.”
As I sat by my front door anxiously awaiting the mail, I told myself ‘today is the day it finally comes.’ The ‘IT’ I had been so patiently waiting for was a letter containing one of two words: PASS or FAIL.

The mail arrived that day, but alas no letter. I would have to wait another two weeks for the results of my RN exam.

When I finally received confirmation that I had passed, I felt vindicated, relieved and ecstatic all at the same time. This was my crowning achievement, my badge of honour, the ultimate reward for four years of note taking, cram sessions and exam writing. It was my proudest moment, nothing could be better than this; or so I believed. Soon, I learned otherwise.

I was getting ready to leave after presenting the Safety Guide for Lunch Monitors at one of my schools, when a little boy came running up to me crying uncontrollably. He told me that he was crying because he was a lunch monitor and had forgotten to attend my presentation. I could not help but smile at his sincerity and commitment, and reassured him that it was okay. But he refused to be consoled until I promised to give him the presentation he had just missed. So I did, and afterwards he gave me a hug and thanked me for “being the bestest nurse ever.”

Only a few months earlier, I could not imagine being more proud than I was when I got my exam results, but I was wrong. The words of a nine-year-old boy put everything into perspective. My proudest moment as a nurse will always be knowing that I have done my “bestest” to help others, regardless of a PASS or FAIL at the end.

Over my career, my patients have brought me great joy: a smile, a gentle touch of someone’s hand, a simple thank you for bringing them comfort. These have made for a gratifying career.

As an outpost nurse for almost 14 years, I remember many wonderful experiences. I enjoyed visiting the community elders to check on their health status. On a particular visit, a very ill patient asked, through an interpreter, if I could dance. Imagine my astonishment.

I had tried the Aboriginal dance, although I was not very good. I started dancing around the kitchen table, swinging my arms and shuffling my feet. My patient watched quietly. Suddenly, he laughed. Everyone laughed, including me.

The patient was still laughing even as I was leaving.

The following week I went on some home visits again. Another patient asked me to dance. Word gets around fast in the north. I obliged her, and she also laughed heartily. They say laughter is the best medicine, it is very healing.

I may soon be known as the dancing nurse.

When I retire I shall miss the children wrapping their arms around my legs, the group hugs, and the patients meeting me in the northern stores, telling me I healed their rash or they felt better. The care, the love, the compassion I have shown my patients has rewarded me beyond what I could ever have imagined.

“Nurse, can you dance?” Not very well, but if it helps you heal, I will oblige.
I came to this wonderful country to work as a nanny and enjoyed working with children so much that I began volunteering at the Hospital for Sick Children. I was so inspired by the nurses who provided care to those tiny infants that I decided to become a nurse.

My biggest challenge was nursing children who were dying, because children are not supposed to die. In the early 70’s, there was no cure for some of the cancers that children had, so many of them died. As a young nurse, I often cried along with families.

After a very busy morning at work many years ago, it was such joy to join my colleagues for lunch. I pressed the elevator button, the door opened and I saw to my dismay a father holding his nine-year-old child. He said to me, “Norma, take him, he is yours.”

Imagine my emotions when I took this child from his dad and found him as cold as ice because he had died. I ran with this little boy to an empty room and placed him on the bed. I then called for help. His dad told me that when his little one got worse at home, the only safe place he could think of was to return him to me. I could not stop crying. My manager and other colleagues called for supports. I had been his primary nurse one week prior to his death.
MEMOIRS of NURSING

18
July/August 2008

I had become an experienced hospital and community nurse. I had gathered many skills along the way. One skill I was eager to accomplish was IV initiation.

I quickly discovered initiation of IV therapy is much more than just a skill. Starting an IV is as intricate and layered as poetry. Most people would balk at this comparison and easily remark that intravenous therapy and poetry are strange bedfellows. At face value, the skill required for IV therapy is concrete, tangible, evidence based and statistical. However, experience, education, thoughts, feelings, perceptions and altruism are just a few of the components an IV nurse employs while performing this skill.

This is my sonnet reflecting the thoughts and feelings when an IV nurse is performing her skill. It alludes to the concept that an IV nurse has to be “cruel to be kind.” The nurse must inflict a painful needle stick in order to help heal.

With Tender Cloak

The most despised is armed with bevel gleam
A learned angel poised for times of woe
Her contest crimson lives silently unseen.
With deft of hand she eagles life below
The firmament, that hides a secret flow.
Her own heart to a skipping beat does drum.
With tender cloak to sanguine path must go
Her earnest thought must thwart and numb
Just as the vertex leader guides the young
The sole determined notion is success.
Her mind, and hand, moves steadily as one
To win that fight unknown with wise finesse.
Kind piercing truly weaves the mind and soul
With Healing hand in hand we make our goal.

When you think of nursing, one would automatically think kind, nurturing, pleasant and eager to serve. During more than 30 years as a R.N, I have seen both kind and perhaps not so pleasant personalities in the nursing profession, but one thing I think most of us do possess is the gift of serving. Some of my most memorable experiences have come outside the facility walls, and have been practised with friends and family.

I have worn many hats in the field of nursing, but my expertise for some time was palliative care. I had the rare and honoured opportunity of helping a very dear friend, with whom I had once worked, transition peacefully and comfortably to meet the angels a few years ago. Friends with whom I had not spoken for years remembered me and called me to this special lady’s bedside. All she could muster in her final days were the words, “pain, pain.”

Jumping into my nursing mode, I immediately spoke with staff and the doctor about meds and treatments that I was using in community health nursing. I would like to think that because of my knowledge base in this field, my friend became more comfortable. Before she lost consciousness, with my ear to her cheek, she whispered, “thank you.”

She died hours later, but I always felt that my presence that day helped her pass, with comfort and dignity. Perhaps these are some of the best gifts a friend and nurse can give.
This picture means many things to me. It represents successful collaboration that resulted in reaching high-risk dads and dads-to-be. In family health, when promoting equal access and equity, the importance of involved fathers is often overlooked and misunderstood.

This photo also represents creativity and innovation in applying communication techniques and teaching/learning strategies that establish and foster therapeutic relationships with a population that is difficult to reach, and often very untrusting.

My clients challenge and stretch me beyond the boundaries of traditional nursing. The many ways in which my clients teach me is recognized in this photo. These youth and fathers are the reason I remain excited to be working as a public health nurse.

Your practice...in pictures

Nurses across the province took up RNAO’s Nursing Week challenge to transform personal and workplace experiences into pictures. Here are your top picks...

SECOND PLACE

WHAT VOTERS HAD TO SAY: This photo “reminds the public that not all males in scrubs are doctors, and that male nurses are equally deserving of our thanks and gratefulness for their wonderful work.”

WHAT VOTERS HAD TO SAY: This photo “represents what nurses do every day...we show compassion, communication, confidence, collaboration and consistency.”

TIED FOR THIRD PLACE

WHAT VOTERS HAD TO SAY: This photo “depicts the reality of the care provided to complex patients...nurses, nurses and more nurses.”

WHAT VOTERS HAD TO SAY: This photo “represents something seemingly unrelated to nursing practice, but an important activity to foster trust, identification and willingness to see the world from another’s point of view.”

WHAT VOTERS HAD TO SAY: This photo “reminds the public that not all males in scrubs are doctors, and that male nurses are equally deserving of our thanks and gratefulness for their wonderful work.”
As president of RNAO’s Tamil Nurses Interest Group (TNIG), Padmini Nadarajah knows how frustrating it can be for patients to explain ailments to healthcare professionals when English is not their first language. It’s especially trying when something serious is wrong.

An RN in cardiology at Mississauga’s Trillium Health Centre, Nadarajah says it’s not uncommon for her to be called upon to translate for Tamil speaking patients who cannot find the right words in English to describe their illness. Two years ago, she was asked to help a man who kept pointing to his chest when describing how he was feeling. Naturally, she says, the doctors and nurses assumed he was having chest pains and were concerned the pains might be a sign of something more serious.

When Nadarajah spoke to him in Tamil and asked him how he was doing, she made quite a different discovery. Although he had been in pain, he was feeling better, not worse. She says it’s rewarding to be able to help people convey the right information and get the right care as a result. Sadly, she can’t do that for everyone. With her job on the busy cardiac unit, it can be hard for her to offer help to patients on other floors.

Tamil community members who do not speak English may get frustrated as they struggle to communicate, but they’re not necessarily finding it easier when they turn to a family member or friend who speaks the same language as their healthcare provider, Nadarajah explains. That individual may be able to communicate basic terms, but is not likely to effectively translate the medical terms patients need to know to understand their conditions and care for themselves after they leave the hospital.

While better access to health information and resources is needed for all people across the country, the challenge is often greater among members of immigrant communities who are struggling to adapt to their adopted country. Many of Canada’s 300,000 Tamil people live in the Greater Toronto Area. According to a 2007 study published in the Journal of the American Medical Association, people from Asian countries, including India and Sri Lanka, can die from heart disease five to 10 years earlier than people from other ethnic groups. And Canadians from Southeast...
Asian communities risk developing diabetes at a rate three to four times the rate in the general population.

Nadarajah believes one of the best ways to help people manage this condition – and perhaps even prevent it – is to give them the information they need, and to encourage them to keep track of their personal health statistics such as medications, blood pressure and allergies. She also knows that if people are going to get the most out of the information they collect, it needs to be in their native tongue.

This spring, TNIG members created a 29-page, pocket-sized booklet for Tamil patients. It has space for seniors to record their family physician’s information, the kinds of medications they are taking and why, and a place to keep track of doctors’ visits. It also acts as a quick reference guide on health topics. The book explains, in Tamil, what blood tests or mammograms will check for, and why it’s important for people to track their height, weight and blood pressure. Nadarajah says if patients take the booklet to doctors’ appointments or hospital visits, it can help health-care professionals learn more about the medications and pre-existing health conditions that can affect their treatment.

“In an emergency, the urgent problem is dealt with and then the patient is sent to the unit,” she says. “After two or three days, you’ll find out they’re taking certain medications.”

The health booklets were distributed to Toronto’s Tamil community in May, when TNIG organized a day-long health fair for seniors at a local high school. More than 300 people filled the school’s cafeteria and classrooms. They heard presentations about community services such as home care, and met with 19 Tamil-speaking nurses who helped them fill out the medical history information in the booklet. Nadarajah says many seniors also had questions about the medications they’re taking, and about how to manage certain conditions such as diabetes.

Many people asked questions about how to eat a healthy diet that incorporates traditional foods such as curry. A diabetes educator was on hand to answer those questions, and provide strategies for being active. According to Nadarajah, many of the seniors were grateful to get the information through presentations and in the booklet, and several told her directly that the health fair helped to answer many of the questions they felt they couldn’t ask physicians who often seem rushed during appointments. While she’s glad the sessions were helpful, Nadarajah says they also demonstrated that there are large gaps in the Tamil population’s knowledge about diabetes.

“People know about (the illness), but they don’t know why they’re doing some things the doctor tells them to do,” she says. “They have trouble understanding when to measure their blood sugar, when to eat, and when to take medication.”

Kavitha Ravivarman was one of the volunteer RNs at the fair. As a case manager for the Central East Community Care Access Centre in Scarborough, Ravivarman, who emigrated from Sri Lanka 14 years ago, sees many Tamil people who would like to receive home care in their first language. While she does her best to make that happen, it isn’t always possible. That’s part of why she was eager to spend some time with people at the fair. She admits, however, that it was hard for the nurses volunteering that day to see everyone who came through the door.

“I was really shocked … I didn’t expect that so many people we’re going to show up,” she says of the attendance. “It exceeded all of our expectations.”

TNIG believes the turnout can be linked to the group’s marketing efforts throughout the community. Members distributed flyers during a South Asian festival in Toronto last spring, and Nadarajah made an appearance on a Tamil radio show to promote the event. She says more than 100 people registered for the fair the same day the radio program aired.

Nursing student Arifahamed Abdul Samad admits he too was surprised by the turnout, but was pleased to see so many people taking the time to learn more about their health. Prevention is something Abdul Samad says he’s learned to be passionate about during his three years of nursing school. A former pharmaceutical sales representative in India, Abdul Samad immigrated to Canada in 2004. He says he’s eager to begin his nursing career so he can give back to his community. When he finishes his BScN, he plans to make health promotion an integral part of his career either working in the community or becoming a nurse practitioner.

“It’s my duty to do that for the community,” he says, because many newcomers to Canada find it hard to balance the need for good health habits alongside the need to adjust to a new culture.

Abdul Samad says he’ll continue to help out at any future TNIG health fairs. Nadarajah is pleased to hear that, especially since she’s already heard from friends and acquaintances asking when the next fair will be held. She’s hoping to make it an annual event so that people can come back and check in with the nurses each year. It’s crucial, she says, to help people manage their health so they can lead full lives in a new country. RN

Individuals’ health statistics were then recorded in a personalized booklet for future reference.
Supporting moms long term

Despite the health benefits, many women are unable to find the support they need to breastfeed long term. By JANE HAYWOOD-FARMER

DURING my clinical placement on the postnatal floor of a Toronto hospital in the fall of 2007, I noticed nurses explaining to patients why breastfeeding is important. They assisted mothers to establish a good latch, and encouraged them if they became frustrated. While observing one nurse as she conducted an assessment, I was surprised to see the patient’s embarrassment when she admitted that she was still breastfeeding her two-year-old daughter, as well as her newborn. I quickly realized her embarrassment was understandable given the judgmental expression of the nurse, and her simple “oh” reply.

Shortly after this incident, I was sitting with fellow nursing students looking at a breastfeeding book that showed a few pictures of mothers breastfeeding their two, three or four-year-olds. The students reacted to the pictures with disgust and made inappropriate comments.

These events alerted me to a new kind of discrimination.

It surprised me that while nurses seem to strongly encourage mothers to breastfeed their newborns; their support is less forthcoming as a child gets older. In fact, my experience has shown me that some nurses express their disapproval of a mother’s choice to breastfeed her children long term. My mother breastfed my siblings and me well past infancy, and continues to encourage them if they become aware of the discrimination these women experience.

These events alert me to a new kind of discrimination.

Although long-term breastfeeding is both promoted and widely practiced around the world, in Canada we have a tendency to disregard the biological or natural age of weaning. According to a 2004 study published in Clinical Obstetrics and Gynecology, women should naturally wean children between 2.5 and seven years of age. Rather than focus on this, we tend to focus on what is culturally acceptable, despite the health benefits of long-term breastfeeding.

Jane Haywood-Farmer is in her final year of nursing at the University of Toronto.
dence to support Merry’s view. According to a study published earlier this year in the Journal of Obstetrics and Gynaecology Canada, 90 per cent of pregnant Canadian women want to breastfeed. By the time their children are six months old, however, just 16 per cent of mothers are breastfeeding exclusively.

Szumlanski says that’s a concern because the World Health Organization (WHO) and Health Canada recommend breastfeeding exclusively for six months, and introducing complementary foods while continuing to breastfeed for up to two years and beyond.

To ensure families such as Merry’s get the support they need, Szumlanski believes Ontario needs a provincial breastfeeding strategy. The creation of such a strategy is something RNAO supports unequivocally. It would require health-care organizations – including public health units, hospitals and clinics – to become Baby Friendly by earning a designation based on the WHO/UNICEF Baby-Friendly Hospital Initiative (BFHI), or Baby-Friendly Initiative for Community Health Services. Launched in 1991, the BFHI lists 10 steps that health-care organizations can use to support successful breastfeeding, including helping mothers to start breastfeeding within 30 minutes after birth. It also recommends that mothers and babies remain together in the hospital, including overnight, and sleep in the same room for the first six months the baby is home. Szumlanski says these practises lead to better health for mother and baby.

“The healthiest choice starts from the first meal, which is that first mouthful of breast milk,” she says.

Joanne Gilmore agrees. Last summer, the nursing manager at Toronto Public Health and member of the panel that developed RNAO’s Breastfeeding Best Practice Guideline for Nurses – a comprehensive tool that helps nurses work with moms – joined NDP health-critic Shelley Martel in calling for a provincial breastfeeding strategy.

Gilmore says supporting breastfeeding moms is crucial, especially when you consider some of the obstacles they face. For instance, it can be hard for a woman who’s had an epidural or Caesarean section to position herself to begin breastfeeding. Caesarean sections also decrease the odds that a baby will be placed right on the mom’s abdomen after birth, a practice Gilmore says encourages breastfeeding. And given that women are now going home from the hospital when the baby is just a few days old, Gilmore says a strong structure of breastfeeding clinics, home visits from public health nurses, and peer support will pay off in future health benefits.

“It’s good for the health-care system,” she explains. “The more babies who are successfully breastfed, the healthier the mothers and the babies will be.”

Merry says it’s also crucial to provide women with more information about breastfeeding. For instance, resources that help parents to understand how to ensure a good latch should be included in prenatal classes. And she has no doubt that nurses will continue to play an invaluable role in that education, ensuring women stick with it for six months, two years, or beyond.
Acceptance = Good Health

Nurses raise awareness about the need to respect sexual orientation and gender identity.

BY JILL SCARROW

For the five to 10 per cent of Ontarians who identify themselves as lesbian, gay, bisexual or transgender (LGBT), accessing health care can mean facing discrimination, and that can cause people to turn away from hospitals and primary care settings. According to Health Canada, more than 20 per cent of LGBT people have unmet health needs, almost double the number reported in the heterosexual population.

During Nursing Week 2008, RNAO and Toronto’s University Health Network (UHN) hosted a forum for nurses about respecting sexual orientation and gender identity as a part of patient-centred care and healthy work environments. Mary Ferguson-Paré, Immediate Past President of RNAO, reminded participants of the association’s position statement on Respecting Sexual Orientation and Gender Identity, and discussed some of the challenges LGBT people face.

“We must work together with respect for everyone, without judgement, and with full acceptance and inclusion of everyone, whether they are staff or patients,” she said, adding that respect is crucial in order to help LGBT people overcome barriers to good health.

One of those barriers is violence.

During her presentation, Ferguson-Paré told the audience that sexual minorities experience violence at a rate up to four times higher than members of the heterosexual population. Facing stigma and discrimination can also lead to psychological stress and poor social supports, she explained. This will take its toll on people’s health.

According to Statistics Canada, more that 40 per cent of LGBT people experienced discrimination in the five years leading up to the release of its 2004 report called Sexual Orientation and Victimization. That’s compared to just 14 per cent of heterosexuals. Ferguson-Paré says these stats are unacceptable and they point to a need to speak out on the issues. She said everyone in the health-care system – whether they’re staff or patients – deserves to live and work free of discrimination.

Nursing Week provided a perfect opportunity to discuss the issues, she added, because it coincided with the International Day Against Homophobia on May 17. This year’s theme was designed to grab the attention of health-care providers.

Highlighting the role RNs can play in respecting and supporting the rights and needs of LGBT people is one of the goals of RNAO’s position statement, adopted by the association’s board of directors in 2007. It also highlights health and wellness issues affected by sexual orientation and gender identity. For example, with respect to client-centred care, all health-care services and programs should ensure the needs of LGBT clients so that they feel welcome. The policy also suggests health-care organizations develop policies and procedures as well as codes of conduct for all staff to help educate them about sexual minorities and the need to treat everyone with respect.

Judy MacDonnell is co-chair of RNAO’s Rainbow Nursing Interest Group, made up of more than 70 RNs and nursing students who are working to empower LGBT nurses and clients. She said the position statement has demonstrated a commitment to LGBT issues, and having a forum for discussion in a large hospital gave UHN staff, as well as those health-care providers from community agencies who attended, the chance to openly discuss issues faced by this marginalized community.

Ferguson-Paré said she was inspired by the discussion that took place during the forum, particularly when a young man who had once lived in the U.S. shared how grateful he was to be living in Canada and working at a place that accepts everyone, regardless of their sexual orientation or gender identity.

Ferguson-Paré, who is also vice president, professional affairs and chief nurse executive at UHN, said she “…was very proud to hear that people are supportive of the work RNAO and UHN are doing.”

UHN is working on its own policies and has an ongoing commitment to respect sexual diversity. Ferguson-Paré believes all health-care organizations must adapt in order to meet the needs of diverse clients and fellow co-workers. She said that in an environment that can be as stressful as health care, its crucial to ensure the workplace is an environment where everyone feels welcome, whether they’re being cared for or providing the care.

JILL SCARROW IS STAFF WRITER AT RNAO.
Nurses say province’s new pesticide ban doesn’t go far enough to protect public health

Many RNAO members were disappointed their voices weren’t heard when the Liberal government pushed through pesticide legislation before it recessed for the summer. The legislation, known as Bill 64, bans the use and sale of pesticides for cosmetic purposes. It was passed on June 18 and takes effect next spring.

RNAO says the law doesn’t go far enough to protect the public’s health. On June 9, President Wendy Fucile appeared before an all-party committee examining the bill, expressing nurses’ concerns that the legislation falls short in two critical areas. She urged the committee to toughen up the bill by:

- withdrawing provisions overriding municipal powers on pesticides; and
- removing a loophole that would allow any other pesticide use to be introduced by regulation

Fucile implored committee members to act on these concerns highlighted by RNAO and other health and environmental groups.

She says that allowing municipalities to retain their bylaws governing pesticide use, which the legislation currently does not do, would send the public a message that cities and towns are full partners in public health. Some existing municipal bylaws, she told committee members, are tougher than the one proposed by the provincial government.

More than 500 members supported RNAO’s call for action by sending letters to Premier Dalton McGuinty, Environment Minister John Gerretsen and then Health Minister George Smitherman. But, despite these objections by members, the legislation passed by a vote of 53 to 17.

While the association recognizes that Bill 64 is an improvement over the current situation – because it bans the sale and use of pesticides – Executive Director Doris Grinspun says: “The exemptions undermine the whole intent of the legislation, which was to protect people’s health through a tough pesticide ban. Nurses wanted the government to show strong leadership on this, but they have let us down.”

Fucile says the association’s work isn’t done, adding that RNAO intends to hold the government accountable for ensuring the legislation protects and enhances the public’s health despite its flaws. She said that includes watching closely as regulations are developed.

Poverty update

RNAO members have been busy this summer attending various community meetings on poverty. The meetings, hosted by Liberal MPPs, are part of the government’s strategy to seek input from members of the public on its poverty reduction plan. At a recent meeting in Guelph, Wellington chapter President Helen Tindale talked of the importance of targeting children, saying every child should be fed a nutritious meal at school, whether they are poor or not. Several other RNAO members have attended sessions, including board members Theresa Agnew, Carmen James Henry, Waterloo chapter President Suzy Young, as well as President Wendy Fucile and Executive Director Doris Grinspun. More meetings are scheduled throughout the summer.

Long-term care report draws mixed reviews

On June 17, the government released a long-awaited report on staffing and care standards in long-term care homes, written by Shirlee Sharkey. The former RNAO president and CEO of St Elizabeth Health Care was asked to develop a framework for staffing and make recommendations on quality of care for residents.

Sharkey argued a minimum standard of care wouldn’t fully address all the issues facing nursing home residents and their families. She recommended the province look at ways to improve the care that is delivered, including the development of annual staffing plans at each home to meet the needs of individual residents.

While RNAO was disappointed the report didn’t specify a daily minimum of 3.5 hours of care per resident, per day, the association was pleased that the government recognized RNAO’s Healthy Work Environment (HWE) best practices as a useful tool for guiding staff in long-term care homes. Executive Director Doris Grinspun says that RNAO will continue to push the government to impose a minimum staffing standard to ensure elderly residents are provided with the best care they need. Grinspun adds the standard is a necessary requirement to make the HWE model operational.

Members interested in reading Sharkey’s full report, and RNAO’s reaction, should visit www.rnao.org
In June, RNAO member and Credit Valley Hospital RN Agnes Daniell was one of four Canadians to receive the title Dame of Grace in the Order of St. John from Ontario’s Lt.-Gov. David Onley. Daniell was nominated for the honour – the equivalent of being ‘knighted’ – by the St. John Ambulance organization in recognition of her 45 years as a volunteer.

To mark its 100th anniversary this year, the Canadian Nurses Association (CNA) created a special award to honour 100 RNs who have had an outstanding or significant impact on the profession. Twenty-seven RNAO members were among the winners who received the Centennial Award. They are: Gail Brimbecom; Gillian Brunier; Sandi Cox; Alba DiCenso; Brenda Done; Gail Donner; Diane Doran; Sandra Dunn; Nancy Edwards; Carol Helmstadter; Elisabeth Jensen; Kathryn Kozell; Joan Lesmond; Donalda MacDonald; Sandra MacDonald-Rencz; Kathleen MacMillan; Sue Matthews; Brenda Morgan; Lynn Nagle; Wendy Nicklin; Michèle Paquette; Elizabeth Paradis; Margaret Risk; Kathryn Kozell; Joan Lesmond; Donalda MacDonald; Sandra MacDonald-Rencz; Kathleen MacMillan; Sue Matthews; Brenda Morgan; Lynn Nagle; Wendy Nicklin; Michèle Paquette; Elizabeth Paradis; Margaret Risk; Joan Lesmond; Linda Silas; Jennifer Skelly; and Meryn Stuart.

At its biennial convention in June, CNA also unveiled a commemorative stamp created by Canada Post to pay tribute to the profession. This year marks the second time the national nursing organization has partnered with Canada Post. The first time was to celebrate 50 years in 1958.

This spring, RNAO Executive Director Doris Grinspun received a Chair Achievement Award in Nursing and Health Human Resources from Canadian Health Services Research Foundation/Canadian Institute for Health Services Research Foundation Chair Linda O’Brien-Pallas. The award, which was first presented in 2004 to recognize the promotion of healthy workplaces for nurses, and for the development of innovative health human resource initiatives, acknowledges Grinspun as a forceful advocate for nursing best practice guidelines in Ontario. “Doris brings passion and drive, as well as expertise to nursing and workplace policies and practices,” O’Brien-Pallas said.

Two former RNAO presidents, Joan Lesmond (left) and Adeline Falk-Rafael (right), assumed important leadership positions this summer. Lesmond was appointed in June as the new Executive Director of the Saint Elizabeth Health Care (SEHC) Foundation. She was RNAO president from 2004-2006, and successfully completed her Doctor in Education in Health Policy this May. Falk-Rafael, who was president from 2002-2004, has become Director (Chair) of the School of Nursing at York University.

RNAO BOARD HIGHLIGHTS

RNAO’s board of directors meets four times a year to discuss issues of importance to the profession. The summer meeting, held this year on June 15, is educational and serves also as orientation for new board members. The board reviewed the association’s goals on social and environmental determinants of health, Medicare and nursing. They also received a briefing on nurse practitioner-led clinics, RNAO’s Best Practice Guidelines program, and the latest services offered by the Centre for Professional Nursing Excellence. To read a complete summary of the topics that were discussed, sign in to the ‘members only’ section at www.rnao.org.
Calendar

August
August 10-15
Creating Healthy Work Environments Summer Institute
Delta Pinestone Resort Haliburton, Ontario

September
September 16
Critical Incident Debriefing: A Workshop for Nurses and Health-Care Professionals
RNAO home office Toronto, Ontario

September 25-26
7th Annual International Elder Care Conference: Older People Deserve the Best
Hilton Suites Toronto/Markham Conference Centre
Markham, Ontario

September 27
RNAO Assembly Meeting
Holiday Inn on King
Toronto, Ontario

October
October 16
Thriving in the Work Environment: Leadership for New Grads Regional Workshop
Hart House, University of Toronto
Toronto, Ontario

October 29-30
4th International Conference: Education for the Future of Nursing: Building Capacity Through Innovation
Hilton Suites Toronto/Markham Conference Centre
Markham, Ontario

October 21-24
International conference and workshops
Nurses: The Solution in Health Care Transformation
Royal Garden Hotel
(www.dragonspringhotels.com)
Beijing, China
For information on making a hotel reservation, contact Nancy Campbell at RNAO: ncampbell@rnao.org

November
November 6-8
Annual Nurse Practitioner Association Conference
London Convention Centre
London, Ontario

November 7
Pandemic Planning: Interdisciplinary Perspective
International Nursing Interest Group Biennial Symposium
Mount Sinai Hospital
18th floor auditorium
Toronto, Ontario
For information:
www.inig-rnao.org,
info.inig@gmail.com

November 21-21
7th International Conference: Healthy Workplaces in Action 2008
Hilton Suites Toronto/Markham Conference Centre
Markham, Ontario

December
December 2
Fight or Flight… New Solutions and Strategies to Workplace Conflict
Regional Workshop
Ottawa, Ontario

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Unless otherwise noted, please contact Victoria van Veen at RNAO’s Centre for Professional Nursing Excellence at vvanveen@rnao.org or 416-599-1925 / 1-800-268-7199, ext. 227 for further information.
Classifieds

INTERNATIONAL INTERPROFESSIONAL
DISCIPLINARY WOUND CARE COURSE. OCT.
17-20, 2008 AND MAY 1-4, 2009
Women's College Hospital, 76 Grenville Street,
Toronto, Ontario. Course description:
longitudinal course of eight days and self-study
modules. For further information: the Office
of Continuing Education and Professional
Development, Faculty of Medicine, University
of Toronto, 500 University Avenue, Suite 650,
Toronto, Ontario, MSG 1V7. Telephone:
416-978-2719/1-888-512-8173.
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Mavericks: Women Reinventing Their Lives
in Mexico. WINTER AND RETIRE IN MEXICO
SEMINARS. Toronto, October 25, 2008.
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System: Using the Power of Hope to Cope
with Dying; and post conference with
Christine Page, MD, Listening to the Wisdom
of the Body. For details please go to
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Carole St. Denis
Nurse Educator, Surgery, The Ottawa Hospital, General Campus
Ottawa, Ontario
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