JANUARY/FEBRUARY 2018

REGISTERED NURSE JOURNAL

Irreplaceable

As the number of RNs in the workforce decreases, so too does confidence that patients will get the care they need, when they need it.

Human trafficking • **30 years of RNJ** • **Introducing the PPE council**

RNAO's 93RD ANNUAL GENERAL MEETING

Thursday, April 19 to Saturday, April 21, 2018
Hilton Toronto,
145 Richmond Street West,
Toronto, Ont.

KEYNOTE PANEL PRESENTATION – SATURDAY, APRIL 21, 2018

Once again this year, RNAO polled its members to choose the topic for the closing keynote panel presentation at the 93rd annual general meeting. Four topic areas were offered, and members chose to focus the discussions on the legalization of cannabis, and what that means for nursing practice in the future.

Recreational cannabis will become legal in Canada this summer.

Participants at this year's closing keynote presentation will hear provocative thoughts from nursing colleagues and politicians on a future with legalized cannabis. These conversations continue to be of interest to all, and as nurses, we will play a unique role in educating the public and pushing for a public health approach.

Mark your calendars and visit RNAO.ca/AGM2018 in March for a list of panelists and further details

AGM REGISTRATION

Access to online registration for events and hotel accommodation is available at RNAO.ca/AGM2018

Need help? Contact Kumudhini Thavaraj at 416-408-5623 or 1-800-268-7199, ext. 221

HOTEL ACCOMMODATION RESERVATION

RNAO has secured a block of rooms at Hilton Toronto at $199 per night (+ taxes), guaranteed until March 17, 2018.

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

VOL. 30, NO. 1, JANUARY/FEBRUARY 2018

REGISTERED NURSE JOURNAL

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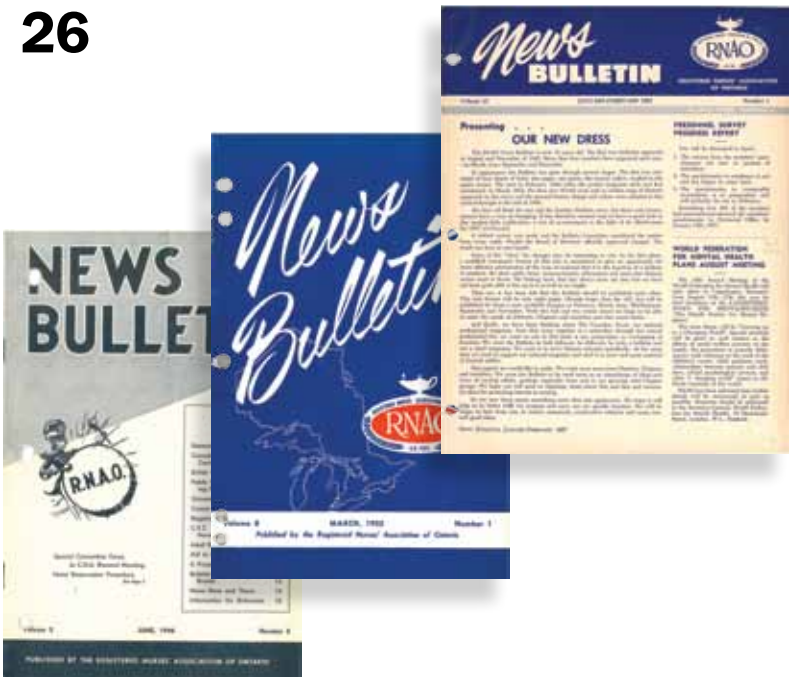

COVER: Jane Rajah (left on cover and above) says overburdened health professionals cared for her older sister Anne (above right) before she passed away in December 2016.

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COVER PHOTO: STEF + ETHAN

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EDITOR'S NOTE KIMBERLEY KEARSEY

Readers help set editorial agenda

For two years, RNAO has been surveying readers of RNJ to get a sense of how people read their professional publication, what they like and dislike about it, and where we can make improvements. More than 500 members have taken the time to respond, and 65 have received gift cards for being among the first to participate following digital release of each issue.

This survey will continue through 2018 because we value and appreciate your feedback. If you haven't already done so, please visit myRNAO.ca/RNJSurvey to tell us what you think. Or watch for the email notifying you of the digital release and follow the link for a chance to win. Your criticisms, compliments, comments, and story suggestions help us shape content that, we hope, is compelling and relevant to the profession and the health system.

Given the incredible appetite for RNAO's best practice guidelines (BPG), it is only fitting that we are introducing a new feature in the *Journal* this year. It focuses on the important work of our IABPG department (page 21). Evidence is at the heart of every BPG, and the same can be said about many other activities of RNAO. The advocacy around RN replacement is a good example of that (page 12). We have 70 years of evidence on the effectiveness of RNs, and we know what is best for patients is the right care in the right place by the right health professional.

We bring you examples of this in every issue, and in this one (page 18) you will meet two Ontario NPs who are providing specialized care for victims of human trafficking. Thanks to their years of experience and specialized skills, they know what vulnerable patients need, and are perfectly positioned to give it to them.

But who knows what patients need more than patients themselves, and their families? Also in this issue, we introduce you to members of our Patient and Public Engagement (PPE) council, all of whom contribute to the work of RNAO by bringing the patient lens to discussions and debates about nursing and health care. **RN**

Have you taken our reader survey? Tell us what you think about RNJ

Visit myRNAO.ca/RNJSurvey to participate.
Or watch your email for notice of the digital release, and complete the survey for a chance to win a Tim Hortons gift card.

Democracy: A right and a responsibility

On or before June 7, we go to the polls to elect a new provincial government. I consider my right to vote an immense privilege and a serious responsibility.

I remember the first time I voted. It was during a provincial election while I was a nursing student. I went to the voting booth with a group of classmates and admit not fully comprehending how important my vote really was. Growing up, my parents took their obligation to vote seriously. Our schedules were arranged so they got to the polling station on time. This was powerful role modelling for me.

When we vote, we make a choice about the type of person we want representing us. We examine what the candidates stand for, how their party's values line up with ours, and the type of community, province or country we want to live in.

I appreciate our electoral system because of the regularity of the election cycle (every four years) and its transparency. When the last provincial election took place in 2014, more than 52 per cent of eligible voters (9.2 million people) cast a ballot. That statistic may not sound impressive, but the 2014 provincial election marked the first time in two decades that voter turnout increased. Still, half of the population didn't bother to cast their vote. As nurses, we have the power to change that reality.

One of the things that makes me most proud about being an RNAO member is the way we engage when an election is on the horizon. We use our knowledge, influence and power to set the agenda. Long before election day, a policy platform is created. It contains the top priorities and recommendations related to nursing, universal access to health services, social determinants of health, and the environment. We also provide fiscal recommendations. This year, we will unveil our platform during Queen's Park Day on Feb. 22.

> "Nurses' day-to-day work provides us with a window on the impact policies can have on people's lives."

For those of you who are new to the process, let me share briefly how our policy priorities are set. It begins with RNAO's deep seated values to advance a society where no one is left behind. To achieve this, our CEO and policy team scan the environment and evidence to bring back to RNAO's board of directors potential areas of focus. Following discussion and decisions by the board on which items to take forward, the policy team sets in motion a comprehensive process to develop the policy platform, including technical backgrounders. These then get transformed into a succinct brochure, developed by our expert communications team. Many of you are familiar with these backgrounders as you have used them to prepare for meetings with MPPs. All 107 MPPs receive their own copy.

Once the election is called, and parties have crafted their platforms, the policy team creates a comparison chart to cross-reference RNAO's "asks" with the promises offered by the political parties. This platform comparison provides nurses and members of the public with a transparent, non-partisan checklist to help understand which party and policies appeal to them most.

In addition, RNAO sends a list of questions to each party leader and posts their answers on RNAO.ca. As the political process unfolds, the association's local chapters organize dynamic and sometimes heated all-candidate debates or town hall meetings – a sign of a healthy democracy.

As RNAO's president, I urge you to immerse yourself in the political process. Read RNAO's policy platform, and educate your family, co-workers and friends on important health issues. Organize or attend all-candidate debates or town hall meetings in your community. Tweet about RNAO's platform and share what's most important to your community. Get in touch with local media by calling them or writing letters to the editor about issues that are making news or are missing from the campaign trail.

The public trusts nurses more than any other health professional. Our day-to-day work provides us with a window on the impact policies have on people's lives. We know the health system in and out, and we know how to make it function better for the benefit of all Ontarians.

This is why we must get involved. This is why I call on every RN, NP and nursing student in Ontario to model the way for your families, your colleagues and your communities. **RN**

CAROL TIMMINGS, RN, BScN, MEd (ADMIN), IS PRESIDENT OF RNAO.

Follow me on Twitter @ctimmings

Visit RNAO.ca/Election2018 at the end of February for your copy of the platform and links to other relevant resources in the lead-up to election day in June.

Personal stories of homelessness fuel policy changes

Like so many others, I often think about the unfair hand homeless persons have been dealt in life, and my mind wonders why. To seek answers, I make a point of taking homeless persons with me to have a coffee or a meal. They have helped me deepen my understanding of why they have become homeless and how they live. I thank them for having fueled my passion to harness RNAO's power to fight for them. This is a fight RNAO member and street nurse Cathy Crowe, recipient of the Order of Canada, has engaged in for almost three decades. Cathy is a social activist, author and filmmaker seeking to eliminate homelessness.

This winter, I have asked myself over and over again: what is wrong with us – as people and as a society? Temperatures have been absolutely freezing. As I turn the fireplace on at my own home because the heating system sometimes isn't enough to keep us warm, I struggle to imagine how someone without a roof over their head can survive on the street. Some don't, and that thought shakes me to my core.

Canada is one of the most affluent nations in the world. How can we be so emotionally detached about the extreme suffering of others? And it's not only in extreme weather conditions that we see the emotional and human distancing people display towards homeless people. Pedestrians in cities across our country walk by homeless persons, avoiding eye contact. It's as though they don't exist. But they do, and homeless persons are people, just like you or me.

In January, I met Joe King, a homeless man on Queen Street in Toronto (see page 10). He seemed pleased that I stopped to talk with him, but the truth is, I was honoured he would be so generous to engage with me. I told him I was on my way to a media conference to speak about better supports for homeless persons. He told me he knew about it. He also knew that the Canadian Forces' Moss Park Armoury had been opened for additional support during the winter months.

When I asked Joe if he used the shelter system, he told me he has severe arthritis, and is not agile enough to get up in the morning and go as quickly as he would be required to in a shelter environment. He said he only goes to a shelter if the weather is so bad he's afraid to be outside. He declined my offer to join us at the media conference that day because he said he needed to make $20. I wished him well and did my part to help him reach his goal.

Sadly, there are thousands of people across Ontario and Canada who are in Joe King's situation. It would be easy to feel overwhelmed by this sad truth if not for the inspiration we can all find in knowing we can make a difference – individually and collectively.

> "CANADA IS ONE OF THE MOST AFFLUENT NATIONS IN THE WORLD. HOW CAN WE BE SO EMOTIONALLY DETACHED ABOUT THE EXTREME SUFFERING OF OTHERS?"

One only needs to spend a short time outside Toronto's Holy Trinity Church to see the importance of the work Cathy Crowe, the Ontario Coalition Against Poverty (OCAP), and others do for one of our most marginalized populations. I was there in January and participated in a service recognizing those who have lost their lives just this winter to homelessness. Three names were added to the Toronto Homeless Memorial.

I also went inside the church and spoke with a group of people who were having a warm meal. When I spoke with one of the organizers, he told me there were about 20 "regulars" and that he enjoyed seeing each of them every day. He too was an inspiration.

As I walked back to the office that day with my colleague Marion Zych, RNAO's director of communications, we spotted a young man – his name is Sean – huddling under a blanket in the extreme cold. We stopped to let him know about the hot lunch close by, and suggested he might want to warm up. He declined the offer of lunch, and said he was okay given the warm air coming up from the grate below him. I told him I was a nurse, and he surprised me with his response. Two decades ago, Sean studied nursing for two years at Loyalist College. For health reasons, he didn't complete the program. He got into construction work instead, but found himself on the street when his anxiety became too intense to continue working. He asked if, at 45, he was too old for nursing. And I reassured him that it wasn't impossible.

We've exchanged emails and we're going to have lunch to talk. Maybe we'll get Sean back to nursing. Wouldn't that be amazing? **RN**

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

Follow me on Twitter
@DorisGrinspun

Filling the gap and giving back

FOR KAYLA KING, SERVING FIRST NATIONS AND ABORIGINAL PEOPLE IN THE NORTH IS A NATURAL FIT.

Growing up, Kayla King didn't always know she wanted to be a nurse. Undecided between hairdressing, cooking and nursing, she took a chance on the latter when she saw the options for growth and the connection to science – a long-time interest. "At that age, you're not really sure what you want to be doing," King admits, so she simply took a leap of faith.

In 2007, she began studying practical nursing at Georgian College. She enjoyed meeting and caring for people as part of her long-term care placement. "It was about making people look nice and feel good about themselves," she says about helping to dress residents and comb their hair. But the experience didn't really help her to determine what she wanted to do in nursing once she finished her diploma.

After her graduation in 2009, King began working immediately for the Northeast Mental Health Centre (now the North Bay Regional Health Centre). She cared for chronically ill mental health patients with schizophrenia and dementia. Although she says the position taught her a lot about the importance of therapeutic interaction between nurses and patients, and how to comfort those with mental health challenges, she wanted more.

Her RN colleagues were true leaders, and she saw through them the possibility for growth in herself. "(They) were really knowledgeable in mental health. They helped to make decisions with the doctors...and they were the lead in any type of code," King recalls.

In 2010, she began the baccalaureate program at Nipissing University with ambitions to improve her critical thinking skills, open up opportunities for leadership, and become more autonomous in her practice. At the same time, she began working on the inpatient surgery unit at the hospital, where she cared for patients with various medical and surgical needs from the recovery room post-operatively, and the emergency department.

Three things you didn't know about Kayla King:

1. She loves to snowmobile.
2. She is passionate about cooking.
3. She got her third tattoo (an elephant) in Thailand.

Building on the knowledge she already had as an RPN, King began to feel more passionate about nursing as she was pushed to think critically on her feet.

Graduating in 2014, she was eager to begin a new chapter in her nursing career, but was unsuccessful finding a full-time RN position at the hospital. When she saw a community health nurse position open up at Nipissing First Nation Health Services, she decided to shift direction.

King says her first year as a community health nurse was very challenging, but exciting. "I was learning about the publicly funded immunization schedule, communicable disease follow up and management, and health promotion and prevention," she says, adding that she often made her own decisions without looking for guidance from someone else. "People were entrusting me to use my knowledge and go with it. (It was) incredibly empowering."

King is from the Beausoleil First Nation, a Chippewa First Nation in Simcoe County. As an Indigenous RN, she says she is able to relate and understand where her patients are coming from, and work with them to improve their health.

As King delved into her role with Aboriginal populations, she began to see gaps and barriers in health services, especially primary care services for First Nations people. "They couldn't find (a primary care provider), they had bad experiences with their current one...transportation issues (or) lack of education about primary health-care services," she says about some of those barriers. To better understand the politics around funding for First Nations' health, King began to do some digging, and connected with RNAO's Nipissing chapter. In 2016, she became the chapter's finance officer.

King wants to continue to make a difference for marginalized populations and expand her nursing scope, so she's decided to go back to school once again to become a primary health-care nurse practitioner (NP). She's currently doing her master's degree with an NP certification by distance education through the University of Toronto. She will be done in 2019.

Although she's busy juggling work and full-time school, King says she loves what she is doing. "I've really found what my passion is," she says, adding that she sees a clear path ahead of her as a primary health-care NP serving First Nations in the north. **RN**

VICTORIA ALARCON IS EDITORIAL ASSISTANT FOR RNAO.

NURSING IN TH

PHOTO: IAN MACALPINE/THE WHIG-STANDARD

Public health RN Nicole Szumlanski (left), with Queen's University students Joseph Lee (centre) and Jennifer Dal Cin, promotes WouldURather, a smoking cessation contest.

Quitting to win

An initiative led by public health nurse **Nicole Szumlanski**, along with students at Queen's University, was created to motivate young adults to kick their smoking habit. As part of Ontario's Leave the Pack Behind program, the WouldURather contest is encouraging Ontario smokers between the ages of 18 and 29 to quit or cut back, offering cash prizes to those who do. Szumlanski, who specializes in smoking cessation, says people are beginning to smoke later in life and that once they become addicted, it is a hard habit to break. She says addictions get worse over time because people associate the habit with their lifestyle, and "…then it becomes part of their life too." The six-week contest offers four different prizes, with the grand prize of $2,500 each going to two winners who quit smoking for good. To learn more about the contest, visit wouldurather.ca (*Kingston Whig-Standard*, Dec. 14)

RNAO to have a say: Wettlaufer inquiry

On Jan. 18, RNAO was granted standing at a public inquiry that will address concerns about the health and well-being of Ontarians living in nursing homes. The association will focus not only on what went wrong in the case of Elizabeth Wettlaufer – a former nurse who murdered eight nursing home residents – but also the shortcomings in long-term care. "This is the only way we can make broad and sustained positive changes that will protect the health and safety of all nursing home residents," said RNAO President **Carol Timmings**. CEO **Doris Grinspun** added that long-term care homes suffer from understaffing of regulated professionals, including RNs, NPs and RPNs. They operate within a system that penalizes homes by reducing their funding when they work to improve the health outcomes of residents. Grinspun said RNAO would like to see employers mandated to disclose termination notices and "any issues related to patient safety" to prospective employers during reference checks. "Let this inquiry be a turning point for residents in nursing homes," she said. "From here on, we must give older Ontarians the respect they deserve by investing in a strong and accountable long-term care sector to help them age safely and with dignity." (*Ottawa Citizen*, Jan. 19)

Managing diabetes in the north

The North East Local Health Integration Network (LHIN), along with a number of other groups, is working hard to ensure northerners have access to the services they need to properly manage diabetes and live healthy lives. "We aim to provide individualized care to promote self-management for our clients," says **Amanda Mathieu**, diabetes program co-ordinator. "This empowers the client to feel confident and informed in managing their care." At West Parry Sound Health Centre, a partner organization, people living with pre-diabetes, diabetes, and gestational diabetes – a temporary condition that occurs during pregnancy – are able to access programs, education and resources to help monitor their blood sugar levels, medications, eating and exercise. The North East LHIN also supports a chronic disease self-management program, which teaches people with chronic health conditions the skills they need to better manage their symptoms. (*Sudbury Star*, Jan. 1)

Wellington County hospitals awarded baby-friendly designation

North Wellington Health Care (NWHC) has earned the

E NEWS

BY VICTORIA ALARCON

Baby-Friendly Initiative (BFI) designation at its Palmerston and Mount Forest Hospitals. The designation, part of a global program launched by the World Health Organization (WHO) and UNICEF, recognizes organizations that promote and support a baby-friendly environment, emphasizing the importance of breastfeeding for infant health. **Nancy Cleary**, NWHC patient care manager and BFI lead, says the designation has been a four-year process with all staff, physicians and midwives participating. "This work reflects North Wellington's desire to provide mothers and infants with the best of care," Cleary says. To achieve the designation, hospital staff provided continual best practice breastfeeding education for nurses, parental support, and rooming-in opportunities, so babies remain with mom following birth. In response to the designation, BFI assessor and trainer **Kathy Venter** congratulated the health-care organization: "You've changed the lives of mothers and children for a lifetime, and that is an amazing accomplishment that you should be so proud of." (*Wellington Advertiser*, Dec. 15)

Women's clinic helps patients

Stevenson Memorial Hospital in New Tecumseth is helping women access the health care they need by providing women-specific services. NP **Lorraine Johnston**, who runs the Well Women's Clinic at the hospital, says she offers physical exams, age appropriate cancer screenings (pap tests, mammograms), and health education for women of all ages. "We review risk assessment for screening, link women to the Ontario breast screening program, (and) provide information about education sites like Cancer Care Ontario and Osteoporosis Canada," said Johnson, who noted she sees 10 patients a day and about 35-40 each month. Before the clinic was set up, women would go to the emergency department or after-hours clinics for care. Johnson explains it's important for women to be advocates for their own health and be informed about the changes to screening guidelines. One tool she recommends is mycanceriq.ca, a cancer risk resource to determine your likelihood of getting breast cancer, kidney cancer, cervical cancer and more. (*Alliston Herald*, Dec. 5)

Letter to the editor

*RN **Beverly Jones** works with the elderly, and wrote a letter to the editor in the Toronto Star (Dec. 29) about expanding a program provided to veterans as a way to address hospital overcrowding.*

Caring for seniors

I am a registered nurse who makes house calls to frail, elderly people. Many of my clients are Second World War veterans who are on the VIP program provided by Veterans Affairs Canada.

I think this program should be expanded to include all Canadians over the age of 85 (or even 80). It supports people in their own homes with many services, including house/garden work and snow shoveling, as well as taxis to doctors' appointments and extended health benefits like dental and foot care. And, more importantly, a counselor to co-ordinate the services.

In the long run, it keeps people independent and out of the hospital or long-term care, which also saves the government money. Makes sense to me.

(From left) Wellington County RNs Reena Jackson and Rachel Duimering, NWHC patient care manager Nancy Cleary, BFI health promotion specialist Doris Balcarras, and RN Erin Balmer celebrate their BFI designation.

PHOTO: RACHAEL OGOREK

NP Lorraine Johnston runs the Well Women's Clinic at Stevenson Memorial Hospital.

NURSING IN THE NEWS

RNAO CEO Doris Grinspun stops on Queen Street in Toronto to chat with Joe King about investments in homeless shelters during the city's coldest months.

Nurses advocate for the homeless

Joyce Rankin, manager at Toronto's Street Health Community Nursing Foundation clinic, says more needs to be done to address the homelessness situation in Toronto. "I think it's terrible...I think it's actually shameful that in a city and a country as wealthy as ours that we are still relying on the volunteer sector to actually do the work for the city," said Rankin. All three levels of government must be involved to actually create meaningful change, she said. In January, Toronto Mayor John Tory asked the province to request the federal government convert the Moss Park Armoury into a 24/7 respite centre until mid-April. At the same time, he announced the city will add more cots at the Better Living Centre and other existing facilities for the homeless. "Homelessness does not end in April, when you have the cold stop, but I think that's the message that the city seems to have...that somehow we have to find shelters only in the cold months," said Rankin. In January, RNAO's CEO and senior policy analyst, **Doris Grinspun** and **Lynn Anne Mulrooney**, respectively, wrote an op-ed about the mayor's response to the situation in Toronto, urging him to take the time to listen to activists. (*CBC News Toronto*, Jan. 6, *Toronto Sun*, Jan. 3)

End-of-life care for the homeless and vulnerably housed

In an effort to expand access to palliative and end-of-life care for the homeless, Ontario's provincial government will provide $245,000 to support a new hospice in downtown Toronto this year. In partnership with Saint Elizabeth Foundation, Inner City Health Associates, and Hospice Toronto, the government will open Journey Home Hospice to provide care to 40-50 people who are homeless and vulnerably housed. "People who are homeless face a variety of health challenges, including a higher risk of illness, significantly higher mortality rates, and barriers in accessing mainstream health services," said **Shirlee Sharkey**, CEO for Saint Elizabeth. Sharkey, a former RNAO president, added many of these individuals deal with chronic health conditions, and complex mental health and addiction issues: "We believe this project will allow us to contribute to and enhance the best practices for serving the end-of-life needs of individuals who are homeless and vulnerably housed." The new four-bed hospice (which will receive funding for another six beds over the next two years) is expected to open in the spring. (*CTV News Toronto*, Dec. 18) **RN**

OUT AND ABOUT

HUBBIES MEET FOR ANNUAL DINNER

For 11 years, RNAO's group home and auto insurance provider, HUB International, has offered members a unique fellowship that includes $2,000 and a one-week placement with RNAO CEO Doris Grinspun. Each year since its inception, the fellows have met to catch up at the annual HUBBIES dinner. This year, the group met in Toronto on Jan. 23. Pictured are: (L to R, back row) Patricia Mlekuz, 2005 HUB fellow; Gerry De Lauro, Patrick Hogan, Sharlene Locke and Jim White, representatives from HUB; Daniel Lau and Patricia Hogg, representatives from RNAO's membership department; and (L to R, front row) HUB representative Carolyn Marczynski; Anita Tsang-Sit, 2017 fellow; Bahar Karimi, 2014 fellow; Grinspun; and Arlene Burla de la Rocha, 2016 fellow.

NURSING NOTES

Ontario welcomes new provincial chief nursing officer

In January, the Ontario government announced nurse practitioner (NP) and long-time RNAO member Michelle Acorn will be Ontario's new provincial chief nursing officer. Acorn, a certified primary health care and adult NP, will provide leadership and strategic clinical expertise at the ministry of health and across the province's public service. She will also co-chair the Joint Provincial Nursing Committee (JPNC) and represent Ontario on the Principal Nursing Advisors Task Force. Acorn has held several leadership roles with RNAO, including co-chair of the expert panel on RNAO's best practice guideline, *Delirium, Dementia and Depression in Older Adults: Assessment and Care*. She was also co-chair for an RNAO-led NP expert panel in charge of developing a toolkit that provides documents, communication strategies and presentations that assist with NP implementation and evaluation in hospitals. Throughout her nursing career, Acorn has been actively involved in implementing Ontario's NP-led clinics. She has held various clinical roles at Lakeridge Health, and is lead for the University of Toronto's Primary Health Care Nurse Practitioner Global Health Program. She completed her doctorate in 2014 with a focus on NPs as the most responsible provider in Ontario hospitals.

CEO Doris Grinspun receives honourary doctorate

RNAO CEO Doris Grinspun has become the first nurse to receive an honourary doctorate from the academic institution Universitat de Lleida in Spain. Nominated by the university's faculty of nursing and physiotherapy, Grinspun (below, with her nominators) was awarded the honour at a ceremony hosted by the university on Feb. 8. "I am truly proud to be the first nurse recognized by this university for my contributions to help move nursing and health care forward," said Grinspun. "Together, we are bringing a spotlight to nurses and the work they do around the world for those who are sick and healthy." The doctorate is given to individuals who have made significant contributions to progress, science, culture or simply because of their personal integrity. Grinspun has been the CEO of RNAO for 22 years and is founder of its internationally renowned Best Practice Guidelines (BPG) program. She has worked closely with the faculty of nursing and physiotherapy at the university in Spain as they work to implement BPGs and become a Best Practice Spotlight Organization (BPSO).

An award for fearless leadership

Claudette Holloway (right), former Region 7 representative on RNAO's board of directors, was recognized for her advocacy and leadership by her nursing colleagues during a Region 7 holiday celebration last year. May Tao, president of the association's Community Health Nurses' Initiatives Group (CHNIG), presented Holloway with the award and a touching tribute highlighting the region's achievements during her time on the board. In 2016, for instance, Region 7 won RNAO Chapter of the Year. "I was moved by the presentation before the award in which I was summarized as a fearless leader," Holloway says. "I was humbled by this title as I still feel I have a long way to go to be a fearless leader. On the other hand, when I get on the topic of speaking for health and nursing... I am passionate and somewhat fearless." In addition to being board representative for four years, Holloway was the assembly representative for Region 7 and part of the executive team for the Maternal Child Nurses' Interest Group (MCNIG). **RN**

Irreplaceable

As the number of RNs in the workforce decreases, so too does confidence that patients will get the care they need, when they need it.

BY DANIEL PUNCH

Jane Rajah could see her sister Anne slipping away.

A long and complex history of health problems had already robbed the 52-year-old of a successful career in the financial industry. Diabetes, weight problems, and struggles with mental health and addiction took their toll, and things only got worse after gastric bypass surgery in 2006 caused a number of complications. By the time Anne was admitted to a Toronto hospital in August 2016 – following several admissions dating back to December 2015 – her diabetes was out of control, she had a blockages in her heart, and multiple bleeding ulcers in her stomach.

As a long-time RN with decades of experience in various health sectors, Jane could recognize the signs of Anne's decline. She saw her sister getting weaker every day, watched her albumin (a protein produced in the liver) levels decline severely, and saw her struggle to keep food down. Eventually, Jane's dynamic older sister, who used to protect her from the racism they faced as immigrants from Sri Lanka in the 1970s, weighed just 34 kilograms (or 74 pounds).

To make matters worse, Jane says the overburdened health professionals who cared for Anne didn't always see what she was seeing in her sister. This was especially true in the rehabilitation unit where Anne spent most of her time after being admitted in August 2016, and where she lost most of the weight. "(Staff members) were run off their feet. It was a really difficult situation," she recalls.

Not only was the rehab unit short-staffed, it also didn't have a single RN on the floor, instead relying on a mix of RPNs and PSWs. This was "extremely surprising" to Jane, especially given the complexity of patients like her sister.

Jane believes Anne's care suffered because the unit lacked the expertise and decision-making skills of RNs. She thinks Anne's health might have improved if staff on the unit had recognized the need for a jejunostomy tube (j-tube, placed through the skin of the abdomen into the midsection of the small intestine to deliver food and medicine), recommended a transfer to critical care days earlier, or alerted physicians about the signs of sepsis she was demonstrating. "I think it's about scope (of practice)," she says. "As an RN, I can make (those) judgment call(s)."

Despite Jane's efforts to advocate on behalf of her sister, Anne continued to decline. She developed multiple infections and eventually went into septic shock. On Dec. 9, 2016, just a few weeks after her 52nd birthday, Anne passed away surrounded by her loved ones.

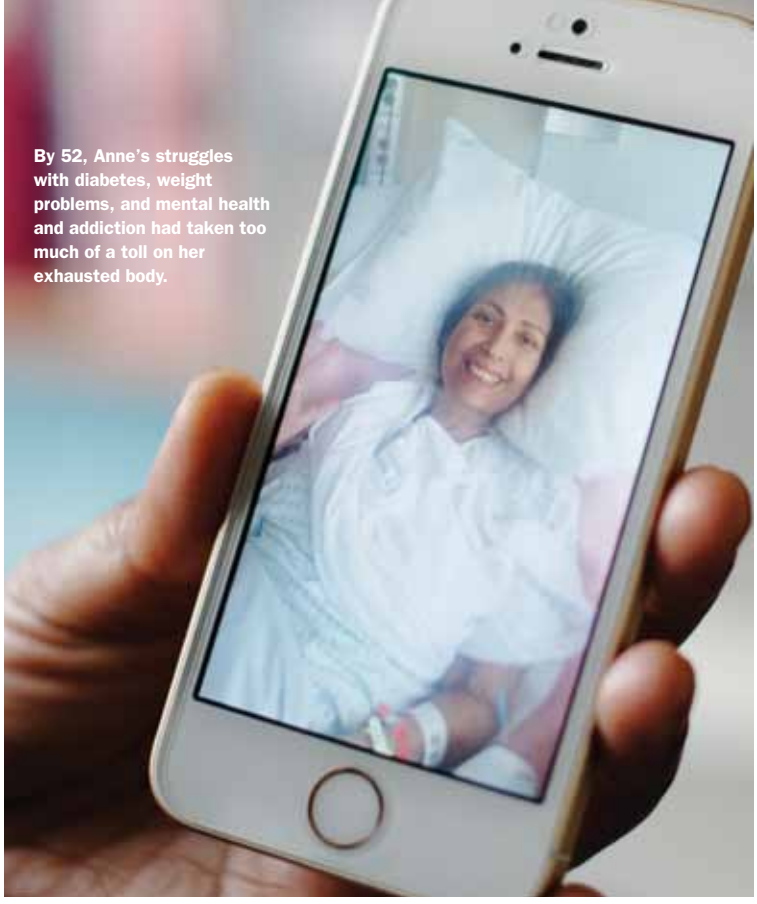
Through it all, Jane remembers how Anne kept a positive attitude and made friends with her roommates at the hospital. "Her smile would light up the whole room," the grieving sister recalls. "She was a very generous and loving spirit."

Jane can't help but wonder if things could have been different for her sister had the staffing situation at the hospital been better. She says Anne's story reflects the unfortunate reality that Ontario's health system lacks RNs. "Most of Anne's journey...I watched as nurses were overwhelmed." she says.

The numbers support Jane's observations. Based on statistics from the Canadian Institute for Health Information (CIHI), RNAO calculates Ontario has the lowest RN-to-population ratio of any jurisdiction in Canada. In fact, Ontario needs about 19,000 more RNs just to catch up with the rest of the country. There have also been fundamental changes to the makeup of the province's nursing workforce. Between 2007 and 2017, the RN share of the nursing workforce dropped from 77.7 per cent to 69.5 per cent, while the RPN share increased from 22.3 to 30.5 per cent.

PHOTO: STEF + ETHAN

RN Jane Rajah says overburdened health professionals who cared for her older sister didn't always see what she was seeing.



By 52, Anne's struggles with diabetes, weight problems, and mental health and addiction had taken too much of a toll on her exhausted body.

What is behind this shift?

RNAO says one of the largest contributing factors is a trend in Ontario towards RN replacement. The association has received numerous calls from concerned members across the province who describe how RN hours at their workplaces are being cut in favour of less educated care providers who command lower salaries. Though these reports come from all sectors, RN replacement seems to be especially prominent in acute care, where RNAO CEO Doris Grinspun says hospitals face financial constraints after years of funding freezes from the government.

"Health organizations are feeling the fiscal crunch," she explains. "In order to cut costs, they are making the short-sighted decision to rely more heavily on care providers without the education and expertise of RNs."

Beginning in 2005, a four-year baccalaureate degree became mandatory to practise as an RN in Ontario. RNs have the competencies, clinical judgment and skills to care for the most vulnerable patients with the least predictable outcomes. According to the College of Nurses of Ontario's (CNO) practice guidelines, "...a more complex client situation and a less stable environment create an increased need for consultation and/or the need for an RN to provide the full range of care requirements." Though all care providers play important roles in health care, Grinspun says RNs cannot continue to be replaced without having a negative impact on patient care, especially when Ontario's population is aging and patient acuity is increasing. "RN replacement," Grinspun says, "...is catastrophic for the quality of care Ontarians receive and also has a negative impact on the bottom line."

The need for RN care is also underscored by seven decades of evidence.

Last spring, RNAO introduced the *70 years of RN effectiveness* database – the largest publicly available source of research on RN impact. It features 645 peer-reviewed studies. More than 95 per cent of these studies found RNs had a positive impact on health and health-care outcomes, including: improved quality of care and patient satisfaction, reduced mortality rates, improved organizational safety, and cost savings. "It is dangerous and unsustainable for Ontario to be losing RNs," RNAO President Carol Timmings said when the database was unveiled at a press conference at Queen's Park in May 2017. "The evidence is clear that we need more RNs if we are going to keep people healthy and safe, as well as keep our health system running well."

RNAO highlighted RN replacement in its 2016 *Mind the safety gap in health system transformation* report, saying the trend "...has compromised the health system's readiness and ability to care for the most complex and unstable patients across all sectors." The report urged the government to adopt a number of recommendations to restore Ontario's RN-to-population ratio, and ensure Ontarians are cared for by the right provider at the right time. Amongst its eight recommendations, the report calls for moving toward an all-RN workforce in tertiary, quaternary and cancer care centres as well as large community hospitals, ensuring all first home health-care visits be completed by an RN, and legislating minimum staffing standards in long-term care, including one NP per 120 residents, 20 per cent RNs, 25 per cent RPNs, and no more than 55 per cent personal support workers (PSW).

But Timmings says these changes will not be possible if Ontario keeps losing RN positions to RN replacement. That's why RNAO sprung into action when members started calling about witnessing replacement in their workplaces. RNAO staff investigated each case by contacting the organization's chief nursing executive (CNE). The association also launched a public awareness and advocacy campaign, taking the issue to politicians at Queen's Park and spearheading an action alert signed by more than 25,000 people. The call has been heard loud and clear. Deputy Minister of Health Bob Bell is on record, stating that: "...patients classified as having tertiary or quaternary needs that are in acute care hospitals require RN care, as do most cancer patients." For this to happen, Timmings says any new hire within these organizations must be an RN and RNAO will continue to push until RN replacement is a thing of the past.

Despite the evidence and advocacy, RN replacement continues. At a meeting with Health Minister Eric Hoskins and his team, Timmings described how RN replacement was the topic she heard over and over again during visits to several communities during her fall tour.

Yet, many RNs find it difficult to speak up about the issue or use their name, for fear of reprisal. *Registered Nurse Journal* reached out to multiple members who preferred not to speak on the record about the RN replacement they had witnessed in their workplaces. Many feared alienating their coworkers or risking their jobs.

One Toronto-area RN working in acute care said she saw staffing decisions made based on budgetary constraints which were "...essentially condoning the replacement of RNs with RPNs..." and leaving RPNs "...pushed beyond their limits." Yet she asked to remain anonymous for this story because she felt she couldn't risk her livelihood by speaking freely about what she saw. "I can't risk making waves when I am only halfway through my

A PLACE FOR ALL NURSES

Since sounding the alarm about the changing skill mix in Ontario's nursing workforce, RNAO has faced criticism from some who suggest the association is pitting RNs against RPNs. RNAO has been adamant in its rebuttal, consistently reiterating that all nurses are essential in a high-performing health system.

The RNs interviewed for this story say they value their RPN colleagues. By speaking out, they simply want to ensure all nurses are put in positions where they can succeed, and all patients are cared for by the appropriate care provider.

Here is some of what they had to say:

- "There was a consensus (at a May 2015 forum on RN replacement hosted by RNAO's Kingston chapter) that every health professional is important and has a role to play. But we need to be careful to ensure they are safely able to provide that level of care." - **Allison Kern, RN and RNAO Kingston chapter president**
- "All categories of nurse (should be) working to their full potential in areas that are appropriate for them." - **Sue Sommerdyk, Windsor RN**
- "This is not about RNs vs. RPNs. It is about following decades of evidence, and keeping patients healthy and safe." - **Doris Grinspun, RNAO CEO**

career and have a family to support and a mortgage to pay," she explains.

In a southwestern Ontario hospital, a veteran RN who also asked not to be named has watched skill mix change dramatically in her unit over the past few years. She says what was once a 50/50 split between RNs and RPNs has become a mix of roughly 25 per cent RNs, 25 per cent RPNs, and 50 per cent PSWs. The total number of staff has not increased. She says the shift has been driven by cost-cutting, and isn't confined to one unit. Across the hospital, RN roles are being lost to RPNs via attrition, and RPNs are working on units that were traditionally all-RN, including critical care and emergency. She says the changes have negatively impacted quality of care, with her unit seeing a higher rate of new wounds and patients being forced to stay longer in the hospital.

"The saddest part for me is, as our population ages and becomes more unwell with more chronic disease, we are reducing the quality of care they are receiving," she says. "It just seems wrong."

As a leader within the hospital, she has voiced her concerns within the organization, but feels her voice was not heard. And she feels she can't raise the issue publicly without being seen as speaking out against the organization.

This sensitive issue has been on nurses' radars for several years. In May 2015, more than 50 people turned out when RNAO's Kingston chapter hosted a local forum to discuss the impact of RN replacement. While a few attendees at the forum chose to share stories about RNs being replaced in their workplaces, chapter president Allison Kern says not everyone felt comfortable making their story more public.

"Nurses are definitely having these conversations," Kern says. "(But) one of the most resounding things to (come out of the forum) is that people can't really speak freely about it."

Faced with the potentially dangerous consequences of RN replacement, some RNs felt they had no choice but to speak up. That was the case in Hamilton in March 2016, when local news outlets reported that St. Joseph's Healthcare was planning to replace RNs with RPNs in its neonatal intensive care unit (NICU).

RNAO members immediately recognized how changing the skill mix in the NICU could jeopardize care for vulnerable infants. Larissa Gadsby, who was chair of RNAO's Pediatric Nurses Interest Group at the time (and is now an RNAO board member), voiced nurses' concerns in an op-ed published in the *Hamilton Spectator*, while Ruth Schofield, a member of RNAO's Hamilton chapter, published a letter to the editor warning about the risks of RN replacement.

"Even when finances get tough, we cannot gamble with risks that present such significant fiscal and human costs," Schofield wrote in the letter.

In Windsor, RNAO member Sue Sommerdyk was one of the loudest voices criticizing Windsor Regional Hospital (WRH) and the ministry of health when it was revealed the hospital was making massive cuts to its RN staffing and hiring RPNs to replace them. According to Sommerdyk, the union was provided notice that 161 RNs were being replaced by 104 RPNs across the hospital's two campuses. As part of efforts to deal with a $20-million budget deficit, the hospital was reversing a 2002 policy decision to employ an all-RN staff at the Metropolitan site (where as many as 91 RNs were to be cut in favour of 89 RPNs).

Sue Sommerdyk, an RN at Windsor Regional Hospital (WRH) (left), was one of the loudest voices criticizing cuts to the RN workforce at the hospital's two sites when she was Ontario Nurses Association (ONA) representative in 2016.

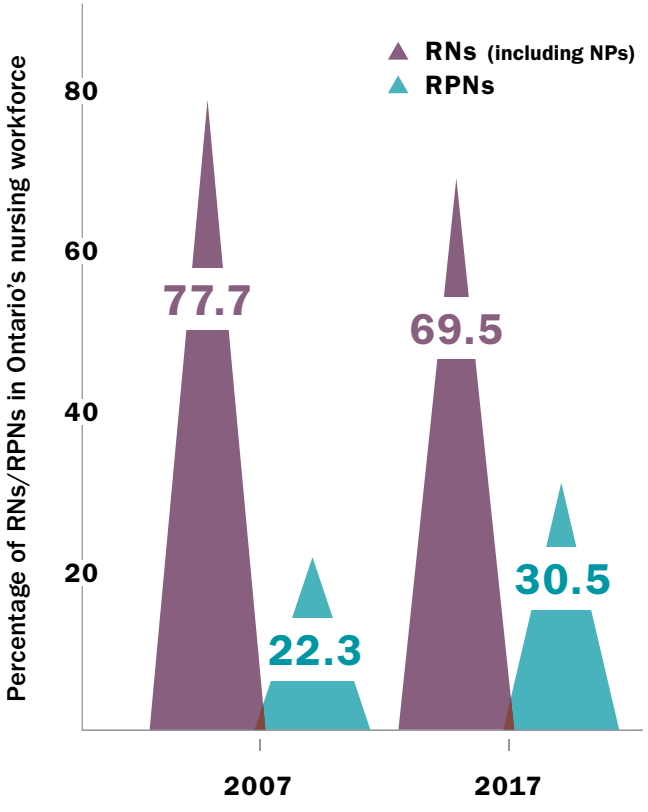
RNs from Windsor Regional Hospital protest cuts to the RN workforce at the hospital in 2016.

RN replacement
BY THE NUMBERS

Number of RNs per 100,000 people in 2016

ONTARIO (the lowest rate in Canada) — 703

REST OF CANADA — 839



Source:
RNAO calculations based on the College of Nurses of Ontario (CNO) Membership Statistics Report 2017 and from previous years of that report.

The *Windsor Star* reported that back in 2002, hospital administrators cited studies showing how an all-RN staff would lead to fewer patient deaths. Yet when cuts were announced in 2016, WRH CEO David Musyj told the *Star* that replacing RNs would have no impact on patient care. "(Patients are) still being cared for by a nurse," he said.

Sommerdyk refutes that claim. Though patients will still be cared for by a nurse, she asks: "... Does that nurse have the time, the knowledge, skill and ability to (provide care) at the same level (as an RN)?"

As a WRH employee and local Ontario Nurses' Association (ONA) representative, she has witnessed over the last two years the consequences of RN replacement. She says the cuts have ruined morale among the nursing staff, and put a tremendous burden on the remaining RNs.

In units like day surgery and oncology, where RNs have been replaced, she says many RPNs don't have the scope of practice to care for complex patients independently. So they are forced to collaborate with one of the RNs, or hand the patient off entirely to an RN. "It has created workload issues," Sommerdyk says. "You end up having RNs with outrageous workloads because now they have to absorb those patients."

And with an overburdened nursing staff, Sommerdyk worries patient care is suffering.

"If you don't have the (staff), or (they're) not as trained as (they) should be, then that's what happens," she says.

> "**RN replacement**... is catastrophic for the quality of care Ontarians receive, and actually has a negative impact on the bottom line." – **DORIS GRINSPUN**

This takes us back to Anne and her grieving sister Jane Rajah, who hopes nurses remember to spend time with their patients, looking, listening and using the assessment skills they learned in school. She can only hope her story resonates with nurses working in all sectors, but recognizes that in order to do that, RNs must have the time. That can be difficult when staffing does not match patient needs.

At Parkdale Community Health Centre, where Jane has spent the last 10 years of her career, she takes pride in being an advocate for her patients. She says advocacy is a big part of an RN's practice, and something she does for each of her clients, just as she did for her sister.

"The sad part of what happened to my sister is I was trying to advocate for her," Rajah says. "It wasn't enough when there wasn't other nurses doing the same because they were so overwhelmed." **RN**

DANIEL PUNCH IS STAFF WRITER FOR RNAO.

POLICY AT WORK

An update on psychotherapy

RNs who practise psychotherapy received some good news in December.

Although the province went ahead and proclaimed the practice a controlled act, it put in place a two-year exemption, effectively delaying its changes from coming into effect.

The legislation was designed to ensure only qualified health providers, such as nurses, doctors, social workers, occupational therapists and psychotherapists, are authorized to use psychotherapy to treat patients. However, unlike other regulatory colleges, which set up practice guidelines and standards in accordance with the new legislation, the College of Nurses of Ontario (CNO) has not. In fact, CNO wants RNs to obtain an order to initiate treatment from a prescriber (a nurse practitioner or physician). The move prompted frustration and alarm among RNs who have long been able to independently initiate and deliver psychotherapy.

RNAO has met with CNO, and has sent several letters to CNO, the premier, and Health Minister Eric Hoskins, pointing out CNO's stipulation fails to recognize the knowledge and skills of RNs who have been practising psychotherapy for years. RNAO also raised concerns about the impact the regulatory body's decision would have on access to care. RNs, particularly mental health nurses, have more education and experience than many other professions initiating and delivering psychotherapy for patients in need of this treatment.

More than 1,000 have responded to RNAO's action alert demanding the regulation be changed.

In his own letter to CNO, Hoskins said "...access to high quality mental health services is extremely important to me and I have full confidence in an RN's ability to make an appropriate assessment to initiate the act."

RNAO vows to vigorously continue its advocacy until CNO reconsiders its decision.

Budget priorities

A committee of MPPs from all three parties is getting advice on what should be included in the next provincial budget. RNAO CEO Doris Grinspun, along with the association's senior economist Kim Jarvi, outlined RNAO's policy priorities during a Jan. 19 meeting.

Recommendations covered five main areas: nursing; universal access to health services; social and environmental determinants of health; and Ontario's fiscal capacity.

In nursing, RNAO said more focus must be placed on the shortage of RN positions. Given Ontario has the lowest RN-to-population ratio in Canada, Grinspun said hiring an additional 19,000 RNs is the only way to shore up the gap. As well, ensuring hospitals, long-term care homes and home care agencies have the right skill mix of nurses is the only way to deal with rising patient and resident acuity levels. Grinspun urged the province to change its archaic funding models for long-term care homes because it penalizes improvements in resident outcomes. For example, funding drops if a home reduces the number of falls or pressure ulcers residents have (as they are deemed "less complex").

RNAO also emphasized the importance of health providers working to their full scope, and making sure care co-ordination is located in primary care. Grinspun and Jarvi stressed that expansion of NP scope should include authorization to perform point-of-care testing, order all diagnostic imaging and ECGs, certify a death, and complete legal forms for mental health services.

RNAO praised the government for its OHIP+ initiative. Expanding the program to include all medically necessary drugs for all residents will improve overall health outcomes, argued Grinspun, and will make Ontario the first province to implement a universal pharmacare program.

Given oral health is a predictor of overall health, RNAO called on the government to invest $10 million in a dental program for low income adults and seniors. The association also urged the province to speed up the progress of work with Indigenous communities to swiftly tackle the epidemic of Indigenous child and youth suicide.

To address social determinants of health, RNAO says the government must follow through with its plan to increase the minimum wage to $15/hour in January 2019. Housing, another key predictor of health, was also cited in RNAO's submission. The association wants the government to invest one per cent of its overall budget to build affordable, accessible housing, and repair existing units. Money should also be set aside to create 30,000 units specifically to meet the needs of people with mental health and addiction issues. RNAO also called on the province to work with other levels of government to ensure there is adequate shelter space across Ontario to address the needs of people who are homeless.

On the environment, RNAO wants dedicated revenue

continued on page 28

Finding HOPE and HELP through *focused care*

NPs at two Ontario clinics specializing in the care of trafficked persons say nurses need more education to help this largely misunderstood population.

BY DANIEL PUNCH

NP Tara Leach met 24-year-old Amanda* two years ago when she came into The Ottawa Hospital emergency department complaining of anxiety and suicidal thoughts. Looking to uncover the source of Amanda's distress, Leach screened her for sexual assault and domestic violence. As a sexual assault nurse examiner (SANE) and clinical lead for the hospital's Sexual Assault and Domestic Violence Treatment Centre, Leach is trained to recognize the signs of these kinds of traumas.

But as Amanda opened up about her life, her story didn't quite add up to a case of isolated sexual assault or intimate partner violence. Instead, she showed telltale signs of a different form of exploitation.

Amanda had recently moved in with a man she called her boyfriend, relocating from Toronto to Ottawa, where she knew practically no one. She was about to start university when the tuition money her parents provided mysteriously disappeared from her bank account. To make matters more confusing, her boyfriend started claiming he had in fact paid her tuition, and she owed him for it. "He made her feel she had this debt (to him), and it needed to be paid," Leach recalls.

As Leach continued to speak with Amanda, she revealed her boyfriend had invited two friends over a few nights earlier, and made arrangements for her to have sex with them. He insinuated that doing so would help pay off her debt. Though she complied, she never felt like the sex was consensual. She was also pretty sure money was exchanged, though she never saw a cent of it.

Leach recognized that Amanda was falling victim to a "Romeo Pimp," someone who portrays themselves as a romantic interest, then ends up sexually exploiting their alleged partner. She says it's one of the most common ways people are recruited into human trafficking.

Like the majority of human trafficking victims in Canada, Amanda didn't self-identify as being trafficked. So Leach had to proceed carefully, and instead focused their conversation on topics like consent, rights, and healthy relationships. She let Amanda know about community services that were available to her, if and when she was ready to leave her current situation. "As a health-care provider, your focus must be on safety and harm reduction, and letting clients know what their options are," Leach explains.

Amanda was never held physically captive against her will, and Leach says few trafficking victims in Canada are. Instead, she says most are controlled by subtler forms of manipulation. "That's the scary part," she says. "You can make people do things they wouldn't normally do by playing on their vulnerability and making (them) feel they don't have a choice."

Though it has been called the fastest growing crime in the world, human trafficking is still largely misunderstood. Many Canadians hear the term and imagine handcuffs and chains on people in a faraway country. But advocates like Leach are working to dispel the myths, raise awareness that trafficking happens regularly in Canada, and help victims get their lives back.

The Canadian department of justice defines human trafficking as "...the recruitment, transportation, harbouring and/or exercising control, direction or influence over the movements of a person in order to exploit that person, typically through sexual exploitation or forced labour." According to Statistics

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

PHOTO: TONY FOUHSE

Ottawa NP Tara Leach helps victims of human trafficking get their lives back.

Canada, there were 206 police-reported cases of human trafficking across the country in 2014. But advocates say this number fails to provide an adequate picture of the problem, since only a small fraction of trafficking cases are reported to police. A 2014 report by the Alliance Against Modern Slavery (AAMS), a Toronto-based not-for-profit, which aims to combat human trafficking and other forms of contemporary slavery, found 551 cases of human trafficking in Ontario alone between January 2011 and December 2013.

Thanks to funding announced this past fall by the provincial government, Leach will be able to provide safe, harm reduction-focused care to even more victims of human trafficking. In September, the province committed $18.6 million to 45 different anti-trafficking projects, including $600,000 to create the H.E.A.L.T.H. (health care, education, advocacy, linkage, and healing) clinic in Ottawa. As an NP with expertise in human trafficking, Leach is leading the first-of-its-kind primary care clinic, which provides health care and social services for people 13 and older who are at risk of human trafficking, are currently being trafficked, or who have been the victims of trafficking in the past.

With more than 40 people already on its waiting list, the clinic will open its doors in late February. Leach will provide head-to-toe physical examinations, vaccinations, and contraception counselling, while also treating chronic illness and injury, infectious diseases, and mental health issues like post-traumatic stress disorder (PTSD). The clinic will operate under the umbrella of Voicefound, a survivor-led charity for victims of child sex abuse and commercial sexual exploitation, and in partnership with Ottawa Victim Services. Thus the H.E.A.L.T.H. team also includes social workers and peer support workers.

Leach says it's extremely important to have a dedicated space to provide health care to people like Amanda because of their unique needs. Unlike busy hospitals, which are plagued by privacy issues and bogged down by competing priorities, H.E.A.L.T.H. is designed as a safe space to provide trauma-informed care at a slower pace. "This is health care how it's supposed to be for these clients," Leach says, noting research shows care for a victim of trafficking can take the same amount of time as care for 20 domestic violence victims.


Mia Biondi

In addition to direct care, the clinic also provides education and training for health professionals and other front-line workers. Leach says this will include classroom-based teaching, as well as opportunities to shadow the clinic's staff to see trauma-informed care in action.

The clinic is a dream come true for Leach, whose interest in health care for trafficked people began while she was working in an emergency department in the U.S. in the 1990s. After noticing patients coming in with stories like Amanda's, she did a lot of independent research on the topic, and volunteered with community based anti-trafficking organizations. After returning to Canada in 2003 and studying to become an NP, she met Voicefound CEO Cynthia Bland while they were both part of an anti-human trafficking panel. They hit it off, and looked for opportunities to work together to provide better access to health care for trafficking victims. H.E.A.L.T.H. is the culmination of those efforts. "I'm very excited to have permission to be the kind of health-care provider I want to be," Leach says.

London NP Mia Biondi is thrilled H.E.A.L.T.H. will provide a unique opportunity for Ontario health professionals to educate themselves about human trafficking. She has been working with victims since 2013, when she joined the London Anti-Human Trafficking Committee as a BScN student at Western University. She has found Canadian health-care providers tend to have less training on how to work with trafficked persons than their counterparts in police and social services. "There is such a lack of knowledge...in Canada," says Biondi, who also worked with trafficked people at the All Saints Community Centre in Toronto in 2014. "We just don't currently have the mechanism to train (health professionals)."

If they don't understand the realities of human trafficking and can't identify it, Biondi says nurses could miss out on opportunities to intervene. A 2014 survey from the Loyola University Chicago School of Law found as many as 88 per cent of survivors visited a health-care provider while they were being trafficked.

This knowledge gap inspired Biondi to submit a resolution to RNAO's 2015 AGM aimed at increasing nurses' capacity to address human trafficking. The resolution passed, and Biondi worked with RNAO to create the *Identification and Aftercare of Trafficked Persons in Ontario* webinar, which she hosted in February 2017 alongside other experts like Caroline Pugh-Roberts, a London anti-trafficking advocate with lived experience.

Then in December 2017, Pugh-Roberts and Biondi teamed up with the Salvation Army to open a drop-in centre for trafficked women in the London area. Like H.E.A.L.T.H., the staff at Cornerstone Dignity – London includes a social worker, a peer support worker with lived experience, and an NP (which Biondi called "the triad"). Since December, Biondi has been conducting health assessments and providing other walk-in health services. In the future, she wants to expand the services provided, and work with health-care organizations to educate clinicians.

She urges all nurses to learn what they can about trafficking, familiarize themselves with the social services in their area, and keep an eye out for red flags. Physically, these can include bruises, burns, branding (often in the form of tattoos), or other signs of violence. Unmanaged chronic illness is also common among trafficking victims, as are sexually transmitted infections and unwanted pregnancy. Most importantly, Biondi says health-care providers need to take their time, ask questions, and create a non-judgmental environment. It might take years for a victim to disclose, but patience and adaptability are crucial when working with people whose trust has been shattered. "Whatever their priority is, you need to make it (your) priority, because they haven't had control for so long," she says. "We need to advocate for them to choose their own pathway." **RN**

DANIEL PUNCH IS STAFF WRITER FOR RNAO.

BPG CORNER

Chile's federal Health Minister Carmen Castillo Taucher (centre) and Gisela Alarcon Rojas, the deputy minister of health (left), join RNAO CEO Doris Grinspun (right) for the live broadcast of the signing of an agreement to become a BPSO Host.

RNAO visits Belgium for training with newest BPSO Direct

In November, RNAO International Affairs and Best Practice Guidelines (IABPG) Director Valerie Grdisa (above left) and Veronique Boscart, former RNAO board member and Canadian Institutes of Health Research/Schlegel Industrial Research Chair for Colleges in Senior Care (above right), delivered a three-day program in Belgium to Antwerp University Hospital (UZA), one of the association's newest Best Practice Spotlight Organizations (BPSO). They worked with (above, L to R) UZA's Paul Van Aken and Danny Van heusden, chief nursing officer and BPSO lead (respectively), and Peter Van Bogaert, nursing and midwifery professor at University of Antwerp. They also presented to a national association representing both the hospital and long-term care sectors. "There is much support in Belgium for the BPSO designation with RNAO," Grdisa says, noting "the excitement reflects a push towards ensuring nurse-led quality improvement is recognized as critical to achieving the strategic goals of a high performing health system."

Peru and Chile sign BPSO Host agreements with RNAO

Two groundbreaking BPSO Host agreements were signed in December with Peru and Chile. Recognizing the BPSO designation as the strongest approach to optimizing patient, organizational and health system outcomes, the Colegio de Enfermeros de Peru (national regulatory body), and the Ministry of Health of Chile (MINSAL), each signed on to the partnerships at media conferences in their respective countries. The agreement with MINSAL, signed by its national minister of health, marks the highest-level BPSO agreement, and was broadcast live in Chile. Applauding the initiative, Ontario's Health Minister Eric Hoskins said: "I am proud that RNAO's work is recognized around the world. The Ontario government has been a strong partner of the RNAO Best Practice Guidelines Program for almost two decades, and we are delighted with the incredible results it has achieved in our country and abroad." Each of the sites also held formal, week-long training sessions delivered in Peru to six hospitals and two universities by RNAO's CEO Doris Grinspun and Maribel Esparza Bohorquez (Colombian BPSO lead), and in Chile by Grinspun, Amalia Silva Galleguillos (Universidad de Chile BPSO lead), and Alejandra Belmar Valdebenito (Clinica Las Condes BPSO lead). Reflecting on her time in Latin America, Grinspun said: "I wish all members of RNAO were able to witness the impact of our BPGs abroad," adding the soon-to-be-released book, *Transforming Nursing through Knowledge*, will provide a snapshot of the success of the BPG program at home and abroad since its inception in 1998.

RNAO's newest BPG

In December, RNAO released *Crisis Intervention for Adults Using a Trauma-Informed Approach: Initial Four Weeks of Management*. This third edition BPG provides evidence-based recommendations for interprofessional teams on how to use a trauma-informed approach when helping adults 18 years and older who have experienced trauma. Recommendations related to nursing practice, education and policy are provided, and apply to all practice settings. The recommendations highlight principles of practice, including safety, trustworthiness, collaboration and choice, empowerment, and building strengths and skills with consideration of cultural, historical and gender issues. Visit RNAO.ca/BPG for a free download.

Coming soon

- On Feb. 28, RNAO will host

continued on page 28

A PUBLIC PERSPECTIVE

RNAO develops a formalized framework for public, patient input on all things health and nursing.

Sholom Glouberman (right) and Janet Roberts (left) co-chair RNAO's PPE council.

BY DANIEL PUNCH

RNAO has always been driven by the powerful voice of nurses. The expertise of more than 41,000 members working in all sectors of the health system has helped the association build political advocacy platforms and best practice guidelines (BPG) that are making a tremendous difference in the health of Ontarians and people around the world.

But RNs, NPs and nursing students understand the most important voice in the health system is that of the public, whether in health of illness. Indeed, nurses are renowned advocates for their patients and clients, and have a long history of collaborating with community organizations and partners.

So when RNAO launched its Patient and Public Engagement (PPE) initiative in the fall of 2016, the association was already regularly engaging members of the public and patients in expert panels that develop BPGs, and as stakeholders for policy documents. But with the PPE initiative, RNAO intended to enhance the contributions of patients and the public to RNAO's mission and values by creating a formalized framework to obtain their input. "I know this work will lead to an even more progressive RNAO, both for nurses and for the public we serve," CEO Doris Grinspun says.

To achieve this goal, RNAO created the PPE council in March 2017. The council is comprised of members of the public, many of whom have experienced the health system as patients, and also health-care providers who have seen the system from the other side. The council meets quarterly to contribute to various RNAO initiatives. Their primary goal is to keep the patient lens front-and-centre.

To understand what the council brings to RNAO, let's meet its 10 diverse and dynamic members.

SHOLOM GLOUBERMAN, CO-CHAIR

Sholom Glouberman had his first significant experience with the health system years ago while caring for his ailing father. Then in 2015, he underwent major surgery and experienced the system as a patient. He has drawn on this history, and a long career in health policy to become one of Canada's leading patient advocates.

Glouberman is the founder of Patients Canada, philosopher in residence at Baycrest, and adjunct professor for the University of Toronto's department of health policy management and evaluation. Recently, his work has focused on building partnerships between patients and health organizations to create patient-friendly performance targets. His book, *The Mechanical Patient*, is about how patients have been understood by the health-care system.

He has also built a strong partnership with nurses and RNAO. He was co-chair of the expert panel for the 2015 *Person- and family-centred care* BPG, and in April 2017, he became the first-ever public representative on RNAO's board of directors. "RNAO has a proven track record as an activist organization," Glouberman says. "And that's why I am pleased to play a part in guiding this important work."

JANET ROBERTS, CO-CHAIR

During a long and distinguished career as an RN, Janet Roberts has made a name for herself as a health-care leader. She spent nearly two decades at Markham Stouffville Hospital, where she

served as vice president and chief nursing executive. She is currently senior director of RES Consulting.

Roberts also knows the other side of health care. She is a cancer survivor who was diagnosed in 2011, and through that experience was able to identify opportunities to streamline the patient experience. "I'm passionate about being patient-centred, and listening to the public's concerns about health care," she says.

A long-time RNAO member, Roberts says the PPE initiative underscores the association's commitment to patients and the public. She appreciates the opportunity to provide feedback on RNAO's work, particularly at a recent meeting where the council reviewed and discussed policy backgrounders for Queen's Park on the Road. "We felt very much that we were heard...and that we had a voice," she says.

MICHAEL CREEK

When Michael Creek speaks about the need to lift Ontarians out of poverty, people listen. His authority comes from the personal struggles with health, homelessness and depression that came after he was diagnosed with non-Hodgkin's lymphoma in 1993. In the years since, Creek has overcome countless barriers to become one of the province's most recognized advocates for marginalized people.

Creek is director of strategic initiatives at Working for Change, which provides education and employment opportunities for people with mental health and addiction issues. He is also a board member for St. Michael's Hospital's Inner City Family Health Team, former co-ordinator of the Toronto Speakers Bureau and Voices on the Street, and has served on government advisory groups that focus on topics such as poverty reduction, mental health, and employment for people with disabilities.

In 2015, Creek was named an Honoured Friend of Nursing as part of RNAO's annual Recognition Awards for his collaboration with the association on the social determinants of health. "Being able to end (poverty) is just as important as ending any disease," Creek said when he received the award.

MARK O'GORMAN

Although Mark O'Gorman's professional background is in information technology (IT), he looks forward to contributing a different perspective to the PPE council. "I come from a completely different world," he says, adding he's specialized in data management over his 30-year career.

Having raised four kids and cared for aging parents in partnership with his wife, a nurse practitioner, his interactions with the health system illustrated a greater need for easier access to personal health information for patients and health professionals. And O'Gorman believes it can be achieved with electronic medical records (EMR).

Bringing data management expertise to the implementation of EMRs was one of the main reasons he applied to be part of the PPE council after seeing an ad in *Registered Nurse Journal*. "I hope I can contribute ideas and approaches based on my experiences, which compliment the practical experience of other members of the council," he says.

MAE KATT

NP Mae Katt has been nursing for more than 36 years, and is a familiar face at RNAO. She grew up on the Temagami First Nation in north-eastern Ontario, and has since become a leader in First Nations health care. Currently, she co-ordinates a mobile opioid-addiction treatment program for people in six remote First Nations in northern Ontario and a high school in Thunder Bay.

Katt's innovative, compassionate, and culturally sensitive approach to health care has been profiled in numerous newspapers and magazines, and earned her an honourable mention in the 2013 Nightingale Awards, handed out by the *Toronto Star*. She was also profiled in the March/April 2016 issue of *Registered Nurse Journal*. Katt is a member of the provincial government's Mental Health and Addictions Leadership Advisory Council, was co-chair of Health Quality Ontario's Quality Standards Advisory Committee on Opioid Use Disorder, and was recently appointed to the provincial Opioid Emergency Task Force.

Mae experienced specialized health care in Toronto after being diagnosed with cancer in 2014. Noting the availability of comprehensive care in the south, she now strongly advocates for the improvement of health-care services in northern Ontario and rural areas.

BRIAN CLARK

As a manager of software companies in Canada, New Zealand, the U.S., and the United Kingdom, Brian Clark has been part of a shift in the software sector from a focus on technology to a focus on the customer. "(Health care) is in desperate need of the same shift, from a provider focus to a patient focus," he says.

He believes technology is the key to achieving that goal by making health care more accessible and traceable, and driving quality improvement. He envisions a system where health professionals are available by email, and patients can access their medical records online.

Clark has collaborated with several health organizations while working with Patients Canada and the Patients Advisors Network, but says he knew practically nothing about RNAO when Sholom Glouberman recommended he put his name forward for the PPE council. Since joining the council, he has met many "fantastic" RNAO

members and staff, and is enjoying being part of RNAO's quest to more actively engage patients and the public.

SUSAN GAPKA

Susan Gapka says nurses are among the strongest advocates for marginalized people. And coming from a long-time champion of social justice, who has advocated for issues like LGBTQ rights, homelessness, addiction, and mental illness, that is quite the compliment.

Gapka has a diverse range of expertise, thanks in part to her lived experience as a trans woman who spent 10 years homeless on the streets of Toronto. As part of Parkdale Community Health Centre's street outreach program three decades ago, and a member of the centre's board of directors, she was at the forefront of harm reduction in Ontario, helping create community based methadone programs. She also founded the Trans Lobby Group, which successfully advocated to get public funding for transition related surgeries and amending the Ontario Human Rights Code to include 'gender identity' and 'gender expression.'

She has previously worked with RNAO and its Rainbow Nursing Interest Group (RNIG) on trans rights projects, and says the work of the PPE council is in line with her interests in health care and policy. "Patient advocacy and engagement is critical to making policy change," she says.

SOL MAMAKWA

As health advisor for the Nishnawbe Aski First Nation in Thunder Bay, Sol Mamakwa is passionate about transforming the health system to make it more equitable for the province's Indigenous communities. And he believes nurses — as frontline care providers in these communities — have an important role to play in improving health services and increasing access.

Mamakwa was part of a panel discussion on Indigenous health at RNAO's 2017 Nurse Executive Leadership Academy, where he shared some of the expertise he gained on the board of directors of multiple northern Ontario health organizations, and as band member of the Kingfisher Lake First Nation.

As part of the PPE council, he hopes to strengthen his partnership with nurses and bring forward the experiences of Ontario's Indigenous peoples. "I think it's important for other members of the council to understand the disparities and the issues faced by these communities," he says.

TAMI SUKHDEO

Throughout her 21 years of experience as an RN in palliative care and critical care, Tami Sukhdeo prided herself in providing inclusive, compassionate care to her patients. Then eight years ago, her career was brought to a standstill by multiple acute and chronic health conditions, including cancer and a cervical spine fusion. As her role changed from nurse to patient, she was saddened that her patient experience was not always positive, and that she wasn't included in her own care plan. "I thought, 'what can I do to sway things... in a different direction?'"

When an opening came up on RNAO's PPE council, she realized it was the opportunity she was looking for. As part of the council, she wants to ensure both sides of health care — caregiver and patient — have equal input into the care a person receives, and believes that building trust is essential to making that happen.

BRENDA TAN

Listening to patients' voices has long been a priority for Brenda Tan. She spent 20 years as a patient relations professional, pioneering the role at North York General Hospital and later working in patient relations at three other Toronto hospitals.

Despite her work history, she still found it challenging to advocate for her husband when he suffered multiple strokes beginning in 2013, and was diagnosed with brain cancer in 2016. "Dealing with medical professionals... isn't any easier for me even with my experience. It's quite difficult sometimes to speak up even though I didn't have a problem advocating for others," she says.

To help give patients and families a voice, she has volunteered with numerous patient advocacy organizations since retiring three years ago. She finds patients are more informed about their rights than they were when she began as a patient relations professional, and she hopes patient-focused groups like RNAO's PPE council will further empower them. **RN**

DANIEL PUNCH IS STAFF WRITER FOR RNAO.

The PPE council is currently looking for two members who are not health professionals. If you or someone you know wants to take part and help shape the future of nursing and health care, visit myRNAO.ca/PPErecruitment

Talking about the hard stuff

Andrea Warnick has been helping children through grief for more than two decades.

RN helps colleagues, families and communities have tough conversations about death with kids.

BY ALICIA SAUNDERS

Death and grief can be intense topics of discussion for anyone, but they can be especially challenging conversations to have with children. Whether it's a family member or friend, breaking the news about death to a child, or helping a child through the grieving process can be difficult, even for professionals.

Andrea Warnick, an RN, registered psychotherapist and thanatologist (someone who studies the sociology and psychology of death), says there are some great resources that can help professionals support patients or clients dealing with loss. In fact, there is a lot of research around grief and death in regard to children, particularly when it comes to cancer. Warnick, who has more than 20 years of experience supporting children, families and communities through the grieving process, says there are many misconceptions she's often trying to dispel.

For instance, it's important, she says, to allow children to be at the bedside of a dying relative. If a child wants to be there, it can help them to understand what is going on. Literature also supports the idea that children do better with honest and early information about a loved one's death. Early information allows kids to have a more realistic perception of death and the dying process, rather than letting their imaginations run wild thinking about what could be happening. Warnick says there's never a point at which it's too early to talk about an illness or dying with children, but there's certainly a point at which it's too late. If children feel there's a secret that's been kept from them, they can start to struggle with trust issues that are a complicating factor when dealing with grief.

Death is an issue that everyone will deal with at some point in their life, but most nurses are not properly educated on how to talk about it with children. Despite her focus on palliative care during her education, Warnick says she did not have a chance to develop skills specific to discussions of death with children when she was first starting out. It was never taught in the classroom, she says. And having worked in a number of positions in nursing at different hospitals, Warnick has found many other health professionals also feel ill-equipped or helpless when it comes to dealing with this difficult issue.

"I realized that social workers had no training in this, and the chaplains had no training in this, and the physicians were terrified of having that conversation with children," Warnick says. It isn't surprising, she adds, since Western society, especially in North America, doesn't like talking about death in general, let alone in conversation with children.

In an effort to raise awareness and answer questions about this issue, Warnick recently helped launch a website that she hopes will make the discussion easier – for health providers, families and friends alike. KidsGrief.ca, a companion to MyGrief.ca, provides online support and resources specifically aimed at helping children. The website was developed by the Canadian Virtual Hospice with support from a number of other organizations, and funding from the Canadian Internet Registration Authority and Hope & Cope, an organization that helps people cope with cancer.

Warnick says KidsGrief.ca touches on many of the concerns she has helped her colleagues address in Q&A sessions and webinars she's hosted as an educator and consultant on the topic. She has been hosting a monthly webinar with Canadian Virtual Hospice since June 2016, and says the website came out of a need to do more to help people feel better equipped to have tough conversations with kids.

The site features an 'Ask a Professional' link, where parents, professionals or volunteers can send messages directly to Warnick and other professionals for advice and feedback. It also provides details on the monthly KidsGrief webinars at which people can ask questions, share information and voice concerns.

When it comes to death, Warnick says nurses are on the front line, often helping patients during the vulnerable hour (2 a.m.) when the hard questions are asked and therapists are often off the clock. She hopes this new website, which launched in November 2017, will not only provide support to nurses, but also be a resource they can give to families trying to cope. **RN**

ALICIA SAUNDERS IS COMMUNICATIONS ASSISTANT FOR RNAO.

The look of change

Registered Nurse Journal has been a benefit of membership with RNAO for decades, and it's changed just as much over the years as members have. **BY KIMBERLEY KEARSEY**

There's a small detail in each issue of RNJ that most people would never notice. But for those of us involved in producing the association's flagship publication, it's far from insignificant. It sits at the top-left corner of the contents page, and tells us the "volume" and "number" of each issue. This year marks volume 30 of *Registered Nurse Journal*. This might imply the magazine has been published for 30 years, and on such an anniversary, of course we'd want to celebrate. And we will.

However, the magazine that members have come to know over the last 30 years is just one iteration of many publications members have turned to for their RNAO news.

This year, we look back in time at an invaluable communications tool that has evolved from the *News Bulletin* in 1946, to *RNAO News* in 1965, *The Registered Nurse* in 1989, *Registered Nurse* in 1992, *Registered Nurse Journal* in 1995, *RN Journal* in 1997, and then back to *Registered Nurse Journal* as we know it in 2002.

Here's our first look back at that evolution...

1946

Vol. 2, No. 2

1952

Vol. 8, No. 1

1957

Vol. 13, No. 1

In 1946, the RNAO *News Bulletin* was a glossy, small format publication, measuring a mere six by nine inches. In 1952, it got a bit of a facelift, but the format and size stayed the same. By 1957, the news of the association warranted more space, and the *News Bulletin* increased in size to a standard letter-sized sheet of paper.

The *News Bulletin* became *RNAO News* in 1965, taking on a number of different looks while under the same name. In 1972, the cover featured a new logo and news that, going forward, the symbol on that cover issue would appear on all printed materials published by RNAO. It was the association's first visual identity of sorts. The symbol remained on the cover for 13 years, disappearing with the introduction of a more updated look in 1985.

In 1989, the publication cycle reset, and volume 1 of the 30 volumes we're celebrating this year was born. *The Registered Nurse* was designed and published externally. "We're looking to the future with hope and anticipation," the contents page read. "As nursing's newest quarterly magazine...we will be bringing you coverage of the issues that are sure to shape the future of your profession. With your ideas, comments and criticisms, we hope to support one of Nightingale's fundamental theories: that good nurses are educated, not trained. Welcome to our first issue."

In 1995, *Registered Nurse* became *Registered Nurse Journal* to "...enhance the professionalism of the journal and lend increased credibility to its articles." The changes were subtle, but staff said they were meant to "...symbolize RNAO's efforts to increase its profile and nursing's voice." Two years later, the magazine got yet another facelift, but more importantly, publication moved in house, under the control of the communications department. Its first in-house managing editor, Julie Abelsohn, wrote in 1997 that the shift "...means we have more control over the quality of the publication and more direct contact with you, our readership." **RN**

KIMBERLEY KEARSEY IS MANAGING EDITOR FOR RNAO.

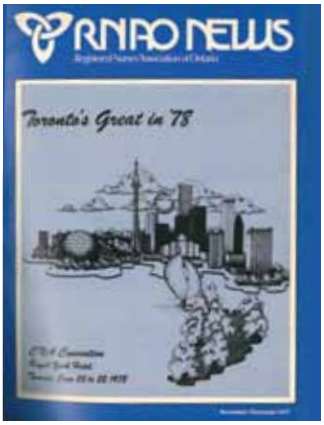
1965

Vol. 21, No. 5

1972

Vol. 28, No. 4

1977



Vol. 33, No. 3

1985

Vol. 41, No. 1

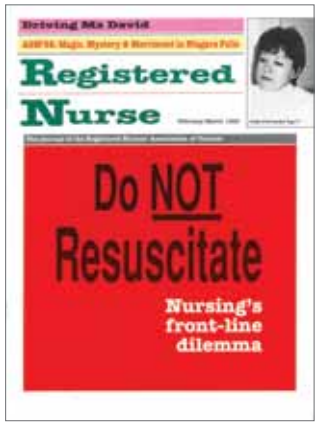
1988

Vol. 44, No. 3

1989

Vol. 1, No. 1

1992



Vol. 4, No. 1

1995

Vol. 7, No. 6

1997

Vol. 9, No. 1

2002

Vol. 14, No. 1

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for more on the evolution of your magazine. And share with us any stories you remember reading or being a part of as RNAO transformed into the organization it is today. You can write to us at editor@RNAO.ca

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POLICY AT WORK (continued from page 17)

sources (federal, provincial and municipal) to address transportation needs.

Grinspun said revenue to advance social and health programs can be found by adopting a more progressive tax system and implementing a cap-and-trade program for carbon emissions.

This year's budget is expected in early spring. **RN**

BPG CORNER (continued from page 21)

a media conference to release its *Implementing Supervised Injection Services* (SIS) BPG. Work began on this BPG in November 2016, when former Toronto medical officer of health David McKeown requested the association develop a guideline focused on the most effective approaches for SIS delivery to people who inject drugs. Promoting health equity for people who inject drugs is heavily emphasized in the BPG through harm reduction, culturally safe, and trauma-informed practices and policies on SIS.

- Perinatal depression is the most commonly occurring mood disorder during pregnancy and postpartum. To address this, RNAO is set to release its second edition of *Assessment and Interventions for Perinatal Depression*. **RN**

Where can RNs, NPs and nursing students go to share their thoughts and experiences, and even a few laughs about their practice? RNAO is proud to welcome you to the Nursing Station.

This brand new blog will showcase the voice of Ontario's nurses via personal anecdotes, thought-provoking editorials, and fun content all nurses can relate to. Whether you want to discuss the joys of the job, the future of the health system, or the best shoes to wear on a 12-hour clinical shift, the Nursing Station will have something for you.

Be sure to check it out at **RNAO.ca/blog**

As a nurse-driven initiative, your stories will bring the Nursing Station to life. RNAO is inviting nurses at all stages of their career to submit content. If you have an idea for a blog post, please contact **nursingstation@RNAO.ca** to discuss.

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IN THE END

BY LINDA ZUCKER

What nursing means to me…

I graduated from nursing at Seneca College in December 1984. During our final student assembly, we had a guest speaker from Toronto's Mount Sinai Hospital. She was a nurse who worked with patients who experienced pain, mostly oncology patients. She was involved in all aspects of end-of-life care. I do not remember her name, but I remember wanting to be her. I loved the way she described her job through personal stories of things she had done, witnessed and felt.

Since graduating more than three decades ago, I have worked in many places, sometimes in two or three part-time positions simultaneously. From family practice offices, to oncology and emergency departments, to clinical and classroom teaching, I have shared my knowledge and stories with future nurses. I completed my baccalaureate degree with honours in 2015. It wasn't easy, but I always knew what I was working towards. I was going to help others with grief, emotional pain, and be honoured to do it. I was going to matter.

I am currently a clinical educator and part-time staff nurse on a palliative care unit, and I am finally that nurse. I love every psychosocial aspect of my job, from talking to families and patients, educating them, hearing their stories, to giving a fellow nurse a hug after they have lost a patient.

In the spring of 2016, I was caring for a man who was nearing the end of his life. As is common at end-of-life, he was not talking or waking up often when his family was visiting. Instead, he woke up late in the evenings when the room was quiet and empty. One evening, he asked me if I believe in God. "Sometimes," I responded. "Can you believe in Him tonight?" he asked. I was unsure how to interpret his comments, but he wanted me to be there for him, so I was. He then asked me: "Can you go get Him (God) for me? I need to speak with Him."

As our conversation continued, he began to speak about his wife, and told me: "I love her very much." I asked if he wanted to tell her that, and made the first of two phone calls I would make that evening to his wife. During their second conversation, he called her 'pussycat,' and told her how much he loved her. She and I were both weepy after that exchange.

Two weeks later, I saw her in the hallway of the palliative care unit. Her husband was still on the unit, but that phone conversation was the last time he had spoken to her. Facilitating and being part of that last conversation is what nursing means to me. It reminds me what I fell in love with during that final assembly presentation at Seneca College in 1984. **RN**

Linda Zucker lives on the shores of Lake Simcoe with her three dogs. She works part time as a palliative care nurse in Toronto and at a hospice in Newmarket, Ont.

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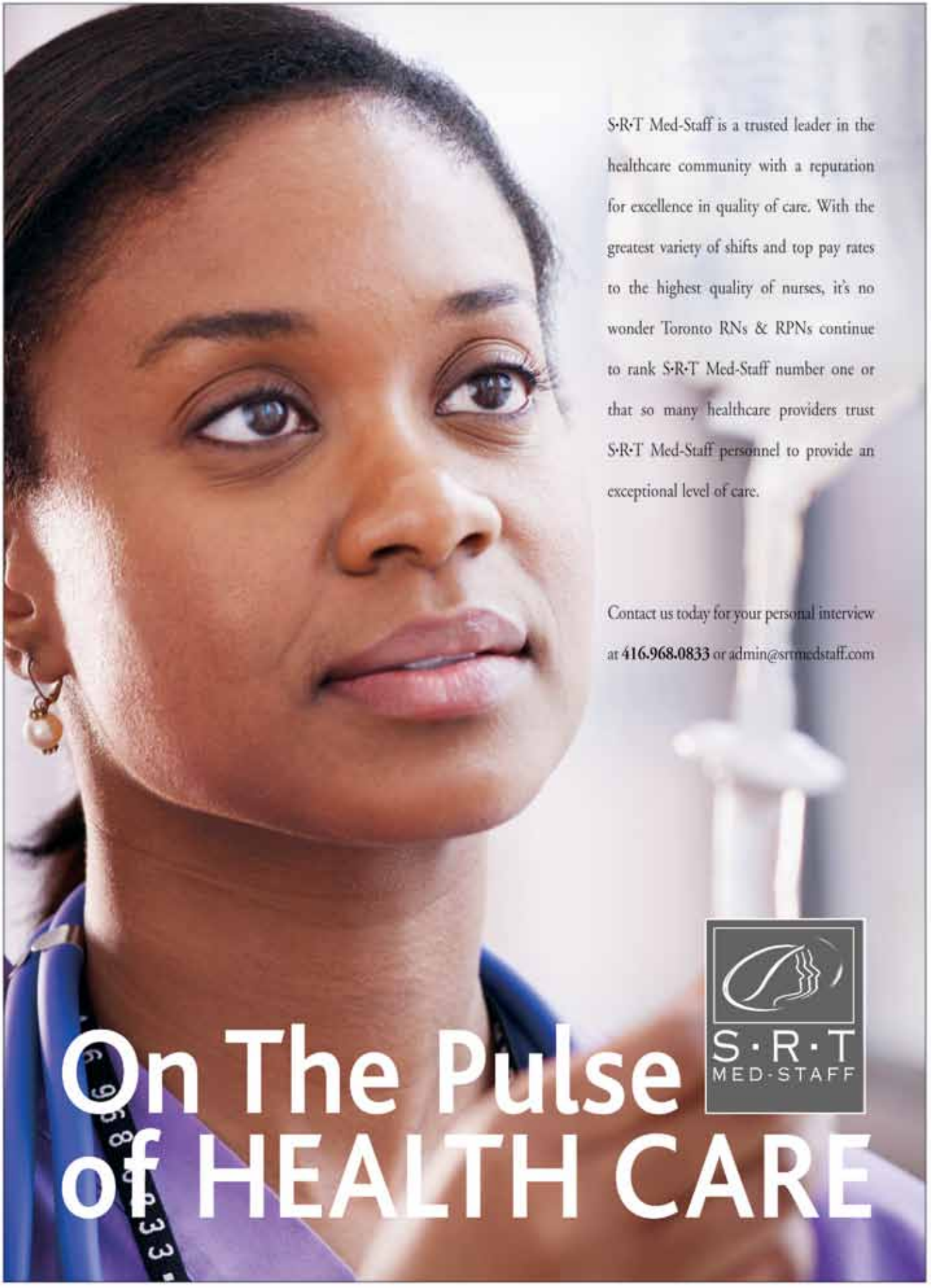
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