Prescribing change
Expanded scope for RNs holds promise to streamline patient care.

Ontario’s new chief nurse • Students lead change • A day-in-the-life of a pediatric RN
NOTICE OF AGM
2016
HILTON TORONTO • MAY 5–7, 2016

Take notice that an annual general meeting (‘AGM’) of the Registered Nurses’ Association of Ontario (hereinafter referred to as ‘association’) will be held at the Hilton Toronto hotel commencing the evening of May 5 for the following purposes:

• To hold elections of directors as provided for in the bylaws of the association (for process of elections, see below*)
• To appoint auditors
• To consider such further and other business as may properly come before annual and general meetings, or any adjournment or adjournments thereof

By order of RNAO Board of Directors

Vanessa Burkoski,
RN, BScN, MSn, DHA
President

* Voting for the AGM shall be by electronic means, during April 2016. Results will be reported at the AGM.

CALL FOR NOMINATIONS
2016-2018 RNAO Board of Directors
DEADLINE: Jan. 8, 2016 at 5:00 p.m.
As your professional association, RNAO is committed to speaking out for nursing, speaking out for health. Your talent, expertise and activism are vital to our success. For the term 2016-2018, RNAO is seeking nominees for:

Member-at-Large, Nursing Administration
Member-at-Large, Nursing Education
Member-at-Large, Nursing Practice
Member-at-Large, Nursing Research
Member-at-Large, Socio-Political Affairs
Interest Groups Representative

Being a member of RNAO provides you with opportunities to influence provincial, national and international nursing and healthcare policy, to discuss and share common challenges related to nursing, nurses, health care, social and environmental issues, and to network with numerous health professionals dedicated to improving the health and well-being of all Ontarians. Becoming a member of RNAO’s Board of Directors will provide you with an extremely rewarding and energizing experience. Over the course of two years, you will contribute to shaping the present and future of RNAO. You will also act as a professional resource for your constituency. Please access the nomination form at www.RNAO.ca. If you require further information, contact Sarah Pendlebury, RNAO board affairs co-ordinator, at spendlebury@RNAO.ca

CALL FOR RESOLUTIONS
DEADLINE: Jan. 8, 2016 at 5:00 p.m.
RNAO encourages individual members, chapters, regions without chapters and interest groups to submit resolutions for review and discussion at the 2016 AGM. Please send enquiries or materials to Sarah Pendlebury, RNAO board affairs co-ordinator, at spendlebury@RNAO.ca

IMPORTANT TO NOTE:
• Resolutions must bear the signature(s) of RNAO member(s) in good standing for 2016.
• A one-page maximum backgrounder must accompany each resolution (this single page will include any references). The font used must be no smaller than Arial 10 or Times New Roman 11. Margins must also be reasonable, e.g. an absolute minimum of 0.7 margin all around.
• All resolutions will be reviewed by the provincial resolutions committee

For clarity of purpose and precision in the wording of your resolution, we recommend it include no more than three ‘Whereas’; and preferably only one, but never more than two, ‘Therefore be it resolved that…’
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COVER: Long-term care RN Saad Akhter (left) says RN prescribing will help residents like John Wood enjoy a better quality of life.
EDITOR’S NOTE

KIMBERLEY KEARSEY

Nothing ventured, nothing gained

Nursing student Janson Chan (page 18) teaches us an important lesson in this issue of the Journal. All it takes to make a big difference is an idea, and it doesn’t even have to be a big idea. Chan wanted to help his teenage brother (who is autistic) in social situations. He started a community program to make that happen. That program is now helping many other youth with autism in other parts of the province find their place in the world. Chan says the success of the program was, at first, “unfathomable.” But the truth is; he had a good idea that filled an important need. And the difference between good ideas that die away and those that flourish are the people behind them.

These are the people we try to feature in each issue of the Journal. Like Chan, Austin White (page 20) was behind an idea worth sharing. He set out to bring awareness of mental health issues to high school students earlier in the health and physical education curriculum in Grade 9. His determination at such a young age is inspiring. And it’s this kind of determination that Chan and White share that helps to turn ideas into reality.

Jacqueline Hanley (page 30) also had an idea: to share a glimpse of her work as a pediatric nurse with anyone who would listen. The result was publication of her touching reflection in a national newspaper last spring, and publication on the pages of the Journal this summer. Hanley’s honest look at caring for kids is perhaps one of our most touching installments ever of In the End. She could have kept her thoughts to herself, but thankfully for us, she decided to share them. And we are all a little richer for reading them.

Do you have an idea? Do you want it to flourish? We can’t promise it will, but we can invite you to share your ideas with us, whatever form they take. Be it a new program or initiative, or a passion you hold dear; with the right recipe of desire and dedication, it may just blossom once you get it out there in the world. If you don’t share, you won’t know. Write to us at editor@RNAO.ca
Many of you are familiar with the concept of patient-centred care. But what does it really mean? Why is it important? And, do you practise it?

In a nutshell, it means providing care that is respectful and responsive to the preferences of the patients or clients we see. It means taking into account not just their needs but their values as well. And, above all, it means ensuring they play an active part in the clinical decisions involved in their care.

Sounds easy enough, but is it?

Does your workplace create the kind of care environment that allows this to happen?

During my career, I have come across pockets of excellence as well as substantial system and organizational failures when it comes to patient-centred care. Several factors associated with the health system and organizational processes can contribute to a lack of patient-centred care. Take, for instance, a patient with cancer who needs to begin chemotherapy next week but must wait three weeks to have a portacatheter inserted because organizational priorities or processes are flawed. When the needs of the patient are secondary to the organization’s needs, patient-centred care is lost.

Our health system, although slowly changing and becoming more integrated, is not currently designed to meet the needs of the population it is meant to serve.

One clear example is that acute care hospitals and primary health organizations are mostly detached from each other, creating gaps in the care that patients receive in either setting. Within healthcare organizations, there are a number of obstacles that impede the delivery of patient-centred care. These include limited hours of access to primary health-care services; diagnostic testing; and allied health professionals. This means people need to be sick, diagnosed and treated during times that are dictated by the system and organizations rather than when people really need them.

Without control over the magnitude of system and organizational factors that create barriers to the delivery of patient-centred care, nurses can grow frustrated, and that frustration is often the source of moral distress. This is where RNAO plays a powerful role in policy advocacy.

RNAO is ever-vigilant in raising nurses’ concerns about the challenges in the health-care system that compromise the delivery of patient-centred care. The recommendations in Enhancing Community Care for Ontarians (ECCO), a report released in 2012, have been generating interest in several jurisdictions. At its core, ECCO recommends shifting the system so that primary care is the anchor. Patients and clients will be cared for before health concerns become acute, and they get the best health outcomes possible.

RNAO is also pushing the system toward patient-centredness by insisting that the time has come for RN prescribing (see CEO Dispatch, page 6, for more on this). By increasing access, people can receive the professional and timely care they deserve. Our call to add NPs in long-term care homes is yet another example of a move to care that is centred on the person.

If you think about it, the concept of patient-centred care is rooted in our professional practice. The skilled and knowledgeable interactions that RNs and NPs have with patients and families can provide the foundation for care delivery with that person in mind.

How are you ensuring this concept is working in your organization? I invite you to write to me and tell me about the difference you are making for your patients. RN

Vanessa Burkoski, RN, BScN, MScN, DHA, is PRESIDENT of RNAO.

“In May 2015, RNAO released its Person- and Family-Centred Care best practice guideline (BPG), formerly the Client-Centred Care BPG. To access the free, downloadable PDF, visit www.RNAO.ca/BPG. To share your stories about making a difference to patients, contact v.burkoski@RNAO.ca

RESPECTFUL AND RESPONSIVE CARE FOR ALL

Respectful and responsive care for all
Unlocking access to health care

RNAO has long advocated for changes to nursing practice and health policy that result in timely access to care for all Ontarians. Health system transformation – the right kind of transformation – opens up our consistently strained and stretched system, allowing people to get the care they need when and where they need it. But, this notion of system transformation may seem intangible to some. What does it look like? And what has RNAO done to propel it forward?

One concrete example is RN prescribing. The latest step toward unlocking timely access that will benefit all Ontarians in a way never seen before. Let’s put this into context. We have 97,996 working RNs in Ontario. Imagine if only a fraction of them, 10 per cent (or almost 10,000 RNs), choose to enhance their education with a 300-hour university course on prescribing. These RNs will go on to provide enhanced care and access to Ontarians, with a vital service. Take this scenario one step further and imagine that every nursing student graduating with their degree in 2020 (our target date) has received, as part of the curricula, the education to begin their nursing practice with prescribing as an entry expectation of their RN role. This would truly unlock timely access in all sectors across our health system.

Is this an illusion? A dream? Not at all. Ontario is already in the initial stages of establishing RN prescribing. And it’s long overdue. The UK has had it for 12 years. Several jurisdictions in Canada have moved ahead of us as well. And RN prescribing fits perfectly with Health Minister Eric Hoskins’ agenda for putting Patients First.

While we continue to advocate for this, we can also proudly embrace some of the other important steps we’re taking – and have taken – to unlock the health system and promote greater access to care.

Since 2012, when RNAO released two seminal reports, Primary Solutions for Primary Care: Maximizing and Expanding the Role of the Primary Care Nurse in Ontario and Enhancing Community Care for Ontarians (ECCO), the association has been calling for changes that anchor the system in primary care. This is the most effective way to deal with a system that is fragmented and suffers from structural duplication. Primary Solutions for Primary Care, the result of an interdisciplinary provincial task force that included all major organizations that represent professionals who work in primary care, provided the impetus for RNAO’s policy recommendation on RN prescribing.

The report was lauded by many and continues to receive traction; driving policy in Ontario, nationally and internationally. Then Health Minister Deb Matthews said the Liberals have “…made tremendous progress in the advancement of primary health-care delivery and we look forward to continuing to make even further progress to realize the increased role our primary care nurses can provide.” PC MPP Christine Elliott commended the task force for putting “…some legitimate ideas on the table.” And NDP MPP France Gélinas said that expanding the scope of practice of RNs “…will transform access and quality within primary care and across the health system.” Don Drummond, then Chair of the Commission on the Reform of Ontario’s Public Services, said he was thrilled to see “…RNAO engage so thoughtfully with proposals to improve the effectiveness, efficiency, and quality of health care. The focus on scope of practice, including an expanded role for nurses, addresses an area the commission believed holds considerable promise.”

There are other tangible examples of RNAO’s stellar evidence-based advocacy that have led to improved access and continuity of care. These include: RN first assistants, formally recognized in 2006; RNs in flexible s dismal they, introduced around the same time; NP-led clinics, first launched in Sudbury in 2007; expanded scope for NPs to admit, treat, transfer and discharge in-patients, finalized in 2012; and the newest role of “attending NP” for nursing homes, announced in 2014 and coming to fruition with allocated funding later this year. All of these policy imperatives began with RNAO and serve to unlock access to health services.

Getting back to RN prescribing as the latest step to unlocking our potential, I urge all members to lead this initiative side-by-side with your professional association and your board of directors. More voices mean greater impact, and more substantial action. Through an expanded RN role that includes prescribing, we will optimize the health system for Ontarians and produce better outcomes clinically and financially.

“RN prescribing fits perfectly with Health Minister Eric Hoskins’ agenda for putting Patients First.”

Doris Grinspun, RN, MSN, PhD, LL.D [Hon], O.Ont, is Chief Executive Officer of RNAO.

Follow me on Twitter @DorisGrinspun
Who knows best?  
Re: The end-of-life debate, March/April 2015

I was disappointed that this article, which I thought was about the new legislation on assisted dying, seemed to mostly express paternalistic views of nurses and comment on palliative care funding.

As a nurse providing patient-centred care, my focus is on the patient’s wishes for their plan of care. Patients who are not cognitively impaired and suffering from either terminal illness or catastrophic illness, which leads to low quality of life, should not have to suffer the final indignity of having paternalistic healthcare professionals tell them what is best for them and not allowing them to choose assisted dying if that is their wish. Who are we as health-care professionals to tell them they must suffer a prolonged death because we know how to manage their pain? As nurses, we are meant to advocate for the patient. This does not mean we should advocate for our own personal values. It is their life and it should be their choice. Nurses should respect their choices.

Jane Penciner
Toronto, Ontario

Wanting an end is not unhealthy  
Re: The end-of-life debate, March/April 2015

Thank you for an interesting article. As an RN with 44 years of experience, I can see how we as nurses want to provide as much support to clients and families as possible in these difficult times. My brother passed away in a wonderful hospice in British Columbia surrounded by the care and support he and his wife needed at that difficult time. I agree that education for both families and caregivers, more palliative beds, and better pain control are needed, however I respectfully disagree with the contention that wanting to take your life is unhealthy. Ultimately, it is the client and their family who need to make this important decision. We as care providers need to respect and support that decision after all the information is provided so that the decision is made with knowledge, respect and comfort.

Barbara Steele,  
London, Ontario

Ruling flawed  
Re: The end-of-life debate, March/April 2015

As a fourth-year bachelor of science in nursing student at Trent University, I have worked with a variety of fabulous health-care professionals who have broadened both my scope and range of perspective. Most express dismay surrounding unnecessary suffering. When the Supreme Court of Canada (SCC) amended the law prohibiting physician-assisted suicide, it recognized the human right of dignity for patients who are suffering. The theme ingrained in nursing academia is that of equity. But where is the equity in this SCC ruling? Unfortunately, those most often in need are unable to benefit due to matters of informed consent. As a student nurse, I recently observed a team of pediatricians and nurses resuscitate a palliative child with little to no quality of life. This child has had countless surgeries and interventions typically performed to preserve or improve quality of life for a healthy child. As an individual passionate about my work with young families, it is both frustrating and heartbreaking to watch the unnecessary pain this child is enduring. Who actually benefits from such extreme measures? I enjoyed this article for the diversity of perspectives and long for a palliative program which addresses the child’s best interests. As a parent who has experienced the heartbeat of losing a child, I would never consider it an option to extend suffering for my own benefit. I hope to see improvement in the future, but at present, this historical ruling remains profoundly flawed.

Lindsay Chmarney
Peterborough, Ontario

CLARIFICATION:  
In February, the Supreme Court of Canada (SCC) struck down the law that makes physician-assisted death illegal. It’s important to clarify that it did not create new legislation or amend the law. The SCC ruling leaves it up to legislators and regulators to develop specifics on how the new law will look.

RN
Halton chapter hosts successful dialogue on elder abuse

To mark World Elder Abuse Awareness Day (June 15), members of RNAO’s Halton chapter joined police, politicians and a number of other organizations for a community forum in mid-June at the Halton Regional Centre in Oakville. Keynote speakers Veronique Boscart, RNAO’s Region 4 board representative, and Ontario Labour Minister Kevin Flynn were present to discuss the need to work together to stop abuse. “It’s something we won’t turn a blind eye to anymore. It’s something we never should have turned a blind eye to in the past,” said Flynn. Boscart, who works as a gerontological nurse in the ER, says many seniors she encounters in the emergency department have been subjected to, or will be subjected to, a form of elder abuse, adding it will often go unreported because many seniors may lack the physical or cognitive capabilities to report it themselves. “We’ve heard some statistics...about one in 11 people right now older than 65...That number is going to change very fast. By 2036, one in four will be older than 65,” says Boscart. “That has huge implications,” in terms of potential incidences of abuse. “It’s about time we put a stop to this,” she says. (Oakville Beaver, June 23)
Nurse practitioners celebrate expanded scope
In an effort to increase patient access to specialists, the provincial government has granted nurse practitioners the power to refer patients to specialists without a doctor’s order. For Leanna Lefebvre, clinic lead for the North Muskoka NP-led clinic in Huntsville, the news represents a positive move forward. “We know that we have a number of nurse practitioners in our communities who are working as a client’s primary care provider, and part of the work that is needed to provide good client care is to be able to speak with and refer directly to specialists,” says Lefebvre. The expansion in scope, and the ability to receive patient reports directly from specialists, eliminates the need for an NP to consult about their patient with the collaborating physician, who would then refer the patient to the specialist, Lefebvre explains. The specialist would then respond to the collaborating physician, who would then have to consult with the NP. Lefebvre says, with this change, these time-consuming and sometimes detrimental steps will be eliminated. (Huntsville Forester, June 25)

HSN takes action against child abuse
It’s estimated 30 per cent of children are abused in northeastern Ontario, and sexual abuse has become the most common health concern for children. For some, this is astounding, but it comes as little surprise to Nancy Horan, manager of the Violence Intervention and Prevention Program at Health Sciences North (HSN) in Sudbury. “It’s my reality,” says Horan, who cares for children who have been sexually or physically abused. In an effort to address these stats, HSN is working towards developing a $55 million children’s health centre (NEO Kids), which would combine all child and family services in one place and decrease the need to leave the region for health care. The centre would include a new Child Advocacy Centre to provide more comprehensive services to children who have experienced sexual or physical abuse, and to help identify abused minors in the community. Horan notes that treating children is quite different from treating adults. Some children may be too young to talk or reluctant to reveal the abuse they have suffered.

PRIDE 2015
Twenty-five nursing students and members of RNAO’s Rainbow Nursing Interest Group (RNIG) hit the pavement in Toronto on June 28 to celebrate Pride 2015. Among the revellers at the city’s 35th annual parade – one of the largest in the world – was RNAO nursing research associate Laura Legere (far left). RNIG has been an interest group of RNAO since 2006 and has been representing the association at the parade since its inception.
RALLYING FOR REFUGEE HEALTH
RNAO members turned out in force on June 15 for the fourth annual Day of Action to draw attention to the need for better health-care coverage for refugee claimants. In front of the Citizenship and Immigration office in Hamilton, RNAO member Sriti Mizan (right) represented the views of nurses. And in Kitchener (below, L to R), RNAO member Elsie Millerd, MPP for Kitchener-Waterloo Catherine Fife, and Pediatric Nurses Interest Group chair Larissa Gadsby spoke out on behalf of those who cannot access primary care and needed medications.

Currently, Horan and her team are working with community partners to build the guidelines for the new centre. (The Sudbury Star, June 24)

Public health advocates for a ban on smoking in public areas
With summer now in full swing, Frontenac, Lennox and Addington Public Health is urging its counties to prohibit smoking in public parks and beaches. It is asking town officials to consider replicating the current smoking bylaws in Kingston, where it is against the law to smoke in municipal parks, outdoor meeting areas and beaches. Nicole Szumlanski, a public health nurse on the tobacco team, says the ban will prevent bystanders from breathing second-hand smoke and help people quit smoking by making it less visible. “It’s about cultural change. It’s about placing the emphasis on the community as a whole to enforce and educate each other,” says Szumlanski. Although police will not be able to ticket every person smoking in parks, bylaws help community members police other people. “They can say: ‘Hey, there’s a sign over here. You can’t smoke here.‘ Szumlanski points out. (The Kingston Whig-Standard, June 26)

Windsor clinic works to overcome low screening rates
To overcome low cancer screening rates, nurse practitioners at the Essex County Nurse Practitioner-led clinic are focusing on an area in east Windsor where fewer residents are seen for regular checkups. Shelley Raymond, the clinical lead, says the area’s aging and often impoverished residents struggle with the cost of transportation, which means accessing proper health care is a challenge. “Patients in that area don’t always go to their family doctor and many don’t have one, so cervical screenings are not followed up with any sort of regularity.”

Statistics from the clinic show that at least 17 per cent of residents in the area don’t have a family physician, and 30 per cent are older than 50, which can be extremely dangerous, Raymond explains. In the case of cervical cancer, research shows it is important to get a diagnosis early to increase survival rates.

Essex NP-led clinic focuses on cancer screening for aging, impoverished residents.
To improve the numbers, nurse practitioners at the clinic have been promoting testing and hosting events to educate women about potential health risks. (The Windsor Star, June 24)

Canada is losing nurses
A new report has found more Canadian nurses left the profession than entered it in 2014. According to the Canadian Institute for Health Information (CIHI), the supply of registered nurses declined one per cent last year, the first downward move in almost 20 years. RNAO CEO Doris Grinspun says that, given population growth and the complexity of patients discharged after shorter hospital stays, the decline is concerning. “We want to show the government sector what’s happening to the workforce because by the time they wake up, it will be too late and we will have patients who will suffer the consequences.”

According to CIHI, Ontario has 714 RNs per 100,000 people compared to the Canadian average of 836 per 100,000 people, leaving Ontario with the second-worst ratio in the country. Canadian Federation of Nurses Unions President Linda Silas explains that the decline in nurses could fuel overtime hours and shows foreseeable problems with the aging workforce. “To ensure patient safety and a sustainable health-care system, we need a national health human resources plan,” says Silas. Newfoundland, Labrador, Prince Edward Island, Nunavut, and British Columbia are experiencing a nursing decline as well. (CBC News, June 23)
**Remembering Lori Dupont**

A decade has passed since Windsor RN Lori Dupont was killed at work by physician and former boyfriend Marc Daniel. Her death marked the beginning of a movement to better protect against violence in the workplace in health-care settings and beyond. A 2007 coroner’s inquest into the 37-year-old’s 2005 murder at Hôtel-Dieu Grace Hospital (now Hôtel-Dieu Grace Healthcare) resulted in a number of recommendations. These came into play when then Premier Dalton McGuinty announced plans to revamp Bill 168, Ontario’s workplace violence legislation, in 2009. The changes to the legislation (which received royal assent in December of that year) led to stricter policies and procedures to deal with workplace violence and harassment. Yet RNAO noted more action was needed to address the lack of protective measures against forms of violence such as teasing, gossiping or bullying that can be just as dangerous as physical assaults. The legislation also came up short in terms of whistleblower protection. In 2009, RNAO released its Preventing and Managing Violence in the Workplace best practice guideline, which defines violence in a more comprehensive way. Nurses in Windsor and beyond have not forgotten Dupont as the catalyst for these important changes over the past decade. A bursary and scholarship have been established in her name at the University of Windsor, and Hôtel-Dieu Grace Healthcare and Windsor Regional Hospital offer an annual Lori Dupont Bursary of $5,000 to assist RN staff with continuing education costs.

**Government announces changes to PHIPA**

In June, Health Minister Eric Hoskins announced that his government will amend the Personal Health Information Protection Act (PHIPA) after a string of high profile privacy breaches, including several involving former Toronto mayor Rob Ford. The amended Act would include mandatory reporting by employers to Ontario’s information and privacy commissioner, as well as to regulatory colleges such as the College of Nurses of Ontario. Although this is a requirement in most other provinces and territories, employers in Ontario are not currently mandated to report violations. Hoskins would also like to see changes to the prosecution process, doubling the fine for individuals caught snooping in patient files (from $50,000 to $100,000) and eliminating the six-month deadline to commence a prosecution. The health minister said these changes to the Act will improve privacy and accountability, noting they are enhancements Ontarians “expect” and “deserve.” He acknowledged the changes are necessary since no one has been successfully prosecuted under the current law, which has been in place for more than a decade.

**Kingston RN takes the helm at CNO**

Nancy Sears, who took on the presidency at the College of Nurses of Ontario (CNO) in June, says her focus is the public interest, safety, confidence and trust. “Without those things, nurses can’t do what they want to do, which is provide really great care,” the Kingston educator/researcher and RNAO member says. Sears is a faculty member at St. Lawrence College. Her research and consulting interests include health-care management and policy, with a special interest in patient safety, health-care service quality, and system design and organization. Sears has worked as an RN in Kingston for 36 years, originally graduating from Queen’s University, then achieving her master’s and doctoral degrees in public and health administration from the University of Toronto.

**New report confirms dangers of using marijuana during adolescence**

The Canadian Centre on Substance Abuse (CCSA) released research in June shedding light on how using cannabis (or marijuana) affects the developing adolescent brain. Its report, the sixth in a series entitled Substance Abuse in Canada, found marijuana is the most commonly used illegal drug among Canadians aged 15 to 24. It also confirms early and frequent marijuana use among this age group involves a greater risk of cognitive and behavioural impairment than marijuana use among adults. CCSA hopes its findings provide valuable and useful evidence to health-care providers and policy makers to “help them develop and employ more effective youth drug use prevention and intervention programs.” The report follows on the heels of RNAO’s release of its latest BPG, Engaging clients who use substances; a comprehensive look at how to assess and manage people with substance-use disorders using evidence-based recommendations. To find out more about RNAO’s BPG, visit www.RNAO.ca/BPG. To find out more about the CCSA report, visit www.CCSA.ca
PREScribing Change

With RN prescribing comes reduced wait times and advanced chronic disease prevention and management. By Daniel Punch

Saad Akhter (right) predicts a better quality of life for long-term care residents like John Wood (left) once RNs are allowed to prescribe.
long-term care RN enters a resident’s room late at night and finds him sick, confused and scared. His blood sugar is through the roof and if it doesn’t come down soon, he could be in real trouble.

The nurse knows he needs insulin, but it’s not within an RN’s scope of practice to provide it without an order from a physician. The home’s only doctor isn’t due in until next week, and isn’t answering the phone. To make matters worse, the resident suffers from dementia, and has just settled in after being transferred from hospital.

“What does the RN do at this point?” asks Saad Akhter, director of care for a Niagara area long-term care home. “Instead of giving insulin, they send the resident to hospital.” At best, the trip to the emergency department will be traumatic. At worst, he’ll come back with a hospital-acquired infection or pressure ulcer, Akhter says.

“(Going to hospital) is not in the best interest of the resident. Their quality of life decreases,” Akhter laments. “If you could provide that care in the home, why wouldn’t you?”

This is why Akhter is a strong advocate for giving RNs the right to prescribe medications. He calls unnecessary transfers to hospital “the biggest challenge in long-term care,” and he believes Ontario could cut expensive and unnecessary transfers in half by allowing RNs to prescribe.

That kind of potential for streamlined care is behind RNAO’s pursuit for expanded scope for RNs as well. The association’s 2012 report Primary Solutions for Primary Care describes an Ontario where primary care becomes the anchor of a health system that provides same-day access, and hinges largely on RNs being able to prescribe in all areas.

“(Expanding RNs’ scope) is going to make us more competent, it’s going to make us more efficient, and it’s going to improve the quality of our care,” says Akhter. “In the next five years, you’ll see a big change (in the health system) if you let us do this.”

In 2013, Premier Kathleen Wynne first announced that she would be expanding the scope of Ontario RNs to a roomful of nurses at RNAO’s annual general meeting. At Queen’s Park Day 2015, Wynne and Health Minister Eric Hoskins reiterated this pledge, and announced that consultations in collaboration with RNAO would begin this year.

“RN prescribing is simply a perfect fit with our vision of a health-care system that puts patients first,” Hoskins explains.

RNAO has already laid out its vision for expanded scope, including three major changes: RNs in the general class should be able to prescribe medications; communicate a diagnosis; and order diagnostic testing and imaging. “RN prescribing is critical to unlocking the power of our health system, reducing wait times in all sectors and services, and advancing chronic disease prevention and management,” says RNAO CEO Doris Grinspun. “Health services in Ontario will be transformed when the province’s 105,793 RNs become eligible to prescribe. It will improve health outcomes and health system efficiency.”

Under RNAO’s proposed plan for prescribing, RNs currently working in Ontario who choose to pursue an expanded scope – it will not be mandatory – would be required to complete a 300-hour course focusing on pharmacology, and including classroom hours, simulation, clinical experience and mentored practice. A final evaluation will ensure that these RNs have all the necessary competencies to prescribe. Once they are authorized to prescribe, their status as prescribers would be tracked by the College of Nurses of Ontario (CNO), which could enhance its quality assurance program to ensure RNs maintain competency. For future RNs, the new prescribing curriculum would be incorporated into undergraduate nursing programs by 2020, making it an entry-to-practice competency.

It’s similar to the path nurses took in the United Kingdom, where RNs were first given the authority to prescribe in 2003. The results speak for themselves. A 2010 report from the Scottish government showed RN prescribing resulted in better care, faster access to medication, and better use of both nurses’ and physicians’ time. Polls have also indicated that public satisfaction and confidence in RN prescribing is high.

RNAs are also prescribing in Australia, Finland, Ireland, New Zealand, Norway, South Africa, the Netherlands and the United States. Closer to home, at least six other Canadian provinces have expanded, or are at various stages of expanding, the scope of their RNs.

But you don’t have to look overseas, or even across provincial lines, to find RNs prescribing. Many Ontario RNs are ordering tests, making assessments, and providing
crucial medications every day under medical directives (orders that defer authority to perform tasks traditionally only performed by physicians). These directives are commonly used to expedite patient care in health-care environments where a physician may not be immediately available.

Natalie Fawcett is supervisor of an Ontario sexual health clinic, where RNs have been working with medical directives for years. Among other things, the clinic’s

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HEALTH MINISTER ERIC HOSKINS

RN prescribing is simply a perfect fit with our vision of a health-care system that puts patients first.”

HEALTH MINISTER ERIC HOSKINS

RNs order tests to screen asymptomatic clients for sexually transmitted infections, then diagnose and prescribe treatments based on positive lab results.

Physicians and nurse practitioners aren’t always available, so allowing nurses to provide these services increases access and promotes continuity of care, Fawcett says. And if a potentially HIV-positive client comes in, they need to be tested and diagnosed as soon as possible in order to prevent spread of the disease. Having the medical directive helps the clinic provide the best care, allowing nurses to screen “well” clients and free up time for physicians to deal with more complex health needs, she says.

But it’s not a perfect system. The directives must be updated at least once every two years – a process that Fawcett calls “a real rigmarole.” Policies, procedures and training must also be renewed along with the directives. Her clinic has the resources to make this happen, but many others do not, which speaks to a disparity in care across the province.

“It would be much easier going forward with RN prescribing,” she says.

Fawcett, a nurse practitioner, is responsible for training RNs on their expanded duties, and says most thrive when working with a broader scope. More important, perhaps, it allows for timely care – particularly for marginalized populations, she adds.

Many of the clinic’s clients are new immigrants, refugees, or members of the LGBTQ community and “they don’t always have an easy time accessing medical systems,” Fawcett notes. Since nurses in many sectors work out in the community, allowing them to couple health promotion with prescribing things like vaccines and contraception would help them meet the needs of people who often fall through the cracks, she says.

Few Ontarians are more marginalized than those living in the isolated communities of the north. Recruiting and retaining health professionals in northern, rural and remote communities is notoriously difficult. This is the reason behind the 2015 RNAO-led task force that produced Coming Together, Moving Forward: Building the Next Chapter of Ontario’s Rural, Remote and Northern Nursing Workforce. RN prescribing is a key recommendation in that report.

In communities like Chapleau, a town of 2,000 located more than a two-hour drive from Timmins, RN prescribing is not only a necessity; it’s a reality. Under medical directives, RNs in the Chapleau Health Services emergency department can assess a patient, order diagnostic tests, and treat with certain medications. In a community with only three physicians – who cycle through the local hospital, family health team and long-term care home – it keeps patients from waiting and sometimes expedites life-saving care, says Anne Morris, Chapleau Health Services’ director of clinical services.

INTERNATIONAL

AUSTRALIA
RNs who complete supplementary education can prescribe scheduled medicines in rural and isolated practices, as part of mental health care, pediatrics, and care for people with disabilities.

IRELAND
After completing additional education, RNs can prescribe from a list representing four clinical areas: drugs for pain relief in hospital; drugs for palliative care; drugs for midwifery; and drugs for neonatal care in hospital.

SOUTH AFRICA
RNs with expanded scope have authority to prescribe treatments for HIV, which helps manage the country’s high rate of the disease.

UK
Since RN prescribing was first implemented in 2003, more than 19,000 RNs have qualified to prescribe in two categories: independent prescribers whose prescribing capabilities are on par with physicians; and supplementary prescribers who prescribe in partnership with a doctor.

IN CANADA
BC
RNs who have the competencies and educational preparation to do so, can order ultrasounds/x-rays and administer schedule I and II drugs without an order in certain circumstances. They can also initiate wound care, including suturing, and manage labour when a primary maternal care provider is absent.

SASKATCHEWAN
The provincial regulatory body has created an additional designation called “authorized practice,” which allows RNs with additional education to diagnose, prescribe and order certain tests based on use of clinical decision-making tools.
“Technically, without a medical directive, if someone comes in with a coronary, the nurse isn’t even supposed to put oxygen on them,” Morris points out.

But medical directives still put the onus on the physician for the care they delegate. With province-wide expanded scope, Morris says RNs could take responsibility for the medications they prescribe and ongoing assessment to ensure they are effective.

“If (registered) nurses are prescribing, it’s their responsibility...and you don’t have to involve the physician until it is necessary,” she says.

Nearly 900 kilometres to the southeast, in a hospital with more staff members than Chapleau has residents, the CEO has seen similar benefits from allowing RNs to initiate medical treatments. The emergency department RNs at Ottawa’s Children’s Hospital of Eastern Ontario (CHEO) use medical directives to treat children suffering from fever, asthma, infections and other ailments.

If all CHEO RNs could have that same prescriptive authority, CEO Alex Munter says children could avoid extended waits for care.

“The more empowered our RNs are, the more effective our operation will be, and the better the quality of care and patient experience will be,” Munter says.

Looking at the broader health system, Munter says the biggest benefits from RN prescribing could be for long-term care and community settings, but these improvements would reverberate through the entire system. The more Ontario can increase the capacity of health professionals working in the community, the healthier people will be at home, and the less they will visit emergency departments, he says.

Facing deficits and an aging population, the Ontario government released its 2015 Action Plan for Health Care with a focus on shifting care out of hospitals and into the community. This, coupled with increasingly complex patients, requires all staff in home and community care to practise to their fullest scope, says Helene Lacroix, a two-decade veteran of the sector. She says RN prescribing will help home care practitioners initiate treatment as soon as issues arise – particularly after hours, when access to physicians is limited.

“Picking up on issues and concerns sooner and being able to respond to them sooner… could have an impact on overall system utilization,” says Lacroix, suggesting cautiously that “…it could be big if the systems and structures and processes are put in place.” This VP of nursing for Saint Elizabeth Health Care is not alone in adding this caveat when discussing such large-scale change for the profession. Many RNs who support an expanded scope also express concern that it will not be as effective without adequate education, clear guidelines, and increased communication between all members of the health-care team and their patients.

Three recent examples of expanding scope of practice could serve as models. Since 2012, nurse practitioners have had the power to admit, treat, transfer and discharge patients in hospitals. This year, 30 nurse practitioner positions will be funded as “attending NPs” in long-term care homes – a role previously reserved for physicians. And, last year, RNs were given the authority to dispense medications, which until 2014 was a delegated act.

“All of these initiatives were triggered and shepherded to the finish line by RNAO,” says Grinspun, and the goal was always to improve timely and quality access. “Such is the goal with RN prescribing,” she adds.

Some may wonder how RN prescribing might affect role clarity, and whether having RNs prescribe could overlap with the responsibilities of NPs and doctors. With this in mind, RNAO involved a diverse variety of health-care stakeholders in its research into expanding RNs’ scope through the Primary Care Nurse Task Force. The association is advocating that RNs prescribe within their scope and competency – depending on their role, experience and setting – rather than from a predetermined list. Given their higher level of education, NPs will continue to have a broader scope than RNs.

As an NP working in a sexual health clinic where RNs already prescribe, Fawcett sees a potential change in scope as a positive. “As long as parameters are very clearly spelled out, I think we can certainly work alongside each other very effectively,” she says.

Akhter says he doesn’t foresee RN prescribing affecting the dynamics between his staff members in long-term care. If there is some overlap in duties, he says it could foster healthy discussions on behalf of patients’ best interests. Ultimately, he says RN prescribing will lead to major benefits for the broader health system – which is good for all Ontarians.

“Our health-care system isn’t in the best place right now, we all know that, so we need to improve and go forward,” Akhter says. “Give us the ability to do more so we can help build a better system.”

The more empowered our RNs are, the more effective our operation will be, and the better the quality of care and patient experience will be.”

CHEO CEO ALEX MUNTER

When could RNs prescribe?

RNAO offers an illustrative (but not comprehensive) list of scenarios where RNs could order tests, diagnose and prescribe. These are divided into three categories:

PREVENTATIVE CARE
Vaccines
Reproductive and sexual health
Prophylactic treatments
Diagnostic testing (i.e. bloodwork)
Disease screening (i.e. fecal occult blood test, mammography, tuberculosis)
Foot care

CHRONIC DISEASE MANAGEMENT
Refills for established medications
Cardiovascular disease
Diabetes
Asthma and respiratory health
Osteoporosis
Chronic mental health
Blood clotting
Wound care

EPISODIC ILLNESS
Otitis media (middle ear infections)
Uncomplicated urinary tract infections
Dehydration
Strep throat
Dermatological conditions
Nausea/vomiting
Non-opioid pain management
Constipation

DANIEL PUNCH IS STAFF WRITER FOR RNAO.
Ontario’s newest chief nurse arrives at Queen’s Park

KAIYAN FU BRINGS A DIVERSE BLEND OF EXPERIENCE AND A DEDICATION TO PATIENT CARE TO THE MINISTRY OF HEALTH.

Ontario’s new provincial chief nursing officer didn’t set out to become a health-care leader. Instead, Kaiyan Fu was led down that path by deeply ingrained values of respect for the elderly and the vulnerable in society.

Fu grew up in Zhengzhou in central China, where reverence for one’s elders is woven into the cultural fabric. Part of a tight-knit family, Fu was also very close with her grandparents. When she was a teenager, her parents moved to Canada as visiting scholars at the University of Toronto (U of T).

Soon afterward, she moved to Guangzhou to study medicine, following in the footsteps of her mother, a pediatrician.

Her path would take a dramatic turn following the June 1989 pro-democracy protests in Beijing’s Tiananmen Square. During the period of political uncertainty that followed the protests, the Canadian government granted many Chinese scholars permanent residency, and Fu was given a special permit to join her parents in Toronto. In November 1989, she landed at Toronto’s Pearson International Airport in unfamiliar surroundings.

“Everything was so foreign,” she recalls. “That was a very long winter for me in a new country, a new culture, a new language, a new everything.”

Becoming a doctor in China requires five to six years of school, compared to upwards of eight years in Canada, and Fu’s Chinese medical school credits were not transferrable toward a Canadian degree. This, coupled with the challenge of a new language, led Fu’s mother to suggest her daughter consider nursing. To overcome the language barrier, Fu recorded every lecture in nursing school at U of T and painstakingly transcribed each recording word-for-word after class.

After graduating with honours in 1995 and being inducted into the Sigma Theta Tau International Honor Society of Nursing, Fu got her start practising part time at Toronto’s Mt. Sinai Hospital and Sunnybrook Health Sciences Centre, where she gained a solid foundation as a point-of-care nurse. Two years later, she became a case manager (or care co-ordinator) at the Scarborough Community Care Access Centre (CCAC) – a role she says reinforced her desire to care for the elderly and vulnerable, and helped shape the rest of her career. In 1999, Fu became the CCAC’s youngest client services manager at just 28-years-old. This was her first taste of administrative leadership, and she never turned back, returning to U of T the next year for her master’s degree in health administration.

“I knew that caring for people is what I really wanted to do... whether it was at the front line or in leadership,” Fu recalls.

After earning her master’s, Fu was recruited by Deloitte Canada, where she worked with health organizations from across the country and gained an understanding of health care at a system level. She spent six years at Deloitte before spending another six as director of nursing innovation and change management at Toronto’s St. Michael’s Hospital.

One of her most significant achievements at St. Michael’s was helping the organization achieve Best Practice Spotlight Organization (BPSO) status in 2012, implementing 17 best practice guidelines. She was also heavily involved with RNAO in other capacities. She served on the association’s board of directors from 2009-2011, and was integral to several RNAO initiatives – including travelling to Beijing to help deliver educational workshops, and hosting four visiting Chinese nurses at St. Michael’s as part of a joint knowledge-sharing project between RNAO and the Beijing Consultation of Culture.

This May, Fu took over as provincial chief nursing officer at Queen’s Park – an opportunity she says is the perfect fit at this point in her career, with her diverse background in different sectors. “It’s almost like I worked for 20 years to prepare me for this job,” she says. RN

Daniel Punch is staff writer for RNAO.

Three things you don’t know about Kaiyan Fu:

1. The name Kaiyan is composed of two characters in Mandarin, meaning “happy” and “smile.”
2. She insists her two children speak Mandarin at home, to keep them connected to their heritage.
3. Kaiyan earned a 100 per cent grade in her math class at medical school in China.
AHEAD OF THE CURVE

Long before they entered their practice, two Ontario nursing students were leading positive change in their communities and beyond. Inspired by personal experiences, Janson Chan and Austin White have tackled major social issues with the help of their peers.

BY DANIEL PUNCH

JANSON CHAN

As a high school senior, Janson Chan remembers seeing a bully pick on a fellow student. “I walked right by because it wasn’t my problem,” he recalls. Only later did Chan learn that same bully was also tormenting his younger brother, Joshua, who has autism spectrum disorder (ASD). Like many autistic youth, Joshua has a hard time navigating social situations, leaving him isolated and an easy target for bullies. “That really hit home for me,” Chan remembers. He could no longer turn a blind eye, and has since made it his goal to ensure teens with autism are not overlooked or victimized.

After graduating high school in 2009, Chan moved from Toronto to London to study medical science at Western University, where he launched an autism awareness club. Through the club, he got involved with Autism Ontario and its “teen night” for local autistic youth. When Chan moved back to Toronto to enter York University’s second-entry BScN program, he found a lack of similar programs for autistic teens. Inspired by Joshua, he launched his own program in July 2014.

The result is the Autism Teenage Partnership (ATP), a volunteer-run community program where teens with autism can interact with their peers and develop their social skills in a safe environment. Participants meet weekly at Scarborough’s Milliken Park Community Recreation Centre for games, crafts, team-building activities and just to be themselves. “People come in from all over the city, from different backgrounds,” Chan explains. “They connect with their peers, make friendships, or just hang out and talk about video games.”

In June of this year, the program opened up its second branch in Kitchener-Waterloo, and Chan is in talks to open a third chapter in York Region. “It’s unfathomable,” Chan says of ATP’s success. “It baffles me how big we got so quickly, starting from just one idea.”

The idea for ATP came after Chan watched his family struggle to find supports for Joshua. Programs for autistic youth are scarce and often tough to access, and tend to drop off after the age of 12. They can also be expensive – in fact, supporting an autistic child can cost families up to $60,000 per year. So as Chan developed the Toronto program, he wanted to ensure it was free, accessible, and could provide families with some respite.

Chan recruited a group of student volunteers, including many of his peers in York’s nursing program. Autism Ontario provided training, and donations came in from York’s faculty of health and the Milliken Park advisory board. The program’s big break came in June 2014, just before its launch, when he submitted a proposal to RNAO’s Region 7, and was given a $3,000 grant to get ATP off the ground.

“RNAO being able to put that...money forward was the real launch pad for ATP,” says Chan, whose mother is treasurer for Region 7. “They’re nurses, so
Janson Chan (right) was inspired by his brother, Joshua (left), to do more for autistic youth.
AUSTIN WHITE

In the darkest days following his mother’s death, Austin White was just looking for understanding.

He was diagnosed with anxiety disorder and situational depression shortly after losing her to a brain tumor in 2011, when he was just 15 years old. White searched for help, but found only stigma. “I couldn’t really talk to anyone about it,” the young nursing student remembers. “I was scared because (people) were judging me. They didn’t understand what I was going through...because no one was educated about (mental health).”

He doesn’t want anyone to have to endure those same struggles alone. While he can’t prevent others from facing mental health issues, he’s worked hard to ensure that if they do, they’ll be surrounded by a more educated and empathetic world.

Entering high school (is) intimidating. You’re supposed to make decisions about your life, to understand who you are, and to find yourself. (That’s) hard when you don’t even understand what’s going on in your own head.

White was among a group of Niagara Region youth who created the Know Mental Health, No Stigma campaign, which pushed for mental health to be included in Ontario’s health and physical education curriculum. The project was part of his role as peer leader with REACT – the local public health unit’s youth-led education and advocacy team. In the summer before White’s senior year of high school, the REACT mental health team was bouncing around ideas for an initiative. They discussed the prevalence of stigma, and it dawned on White; Ontario students are taught about their physical health in high school, but lack education on mental health. The Ontario health and physical education (HPE) curriculum, as taught to Grade 9 students, made little mention of mental health and hadn’t been updated for 15 years. The group decided this needed to change.

“Entering high school (is) intimidating,” White explains. “You’re supposed to make decisions about your life, to understand who you are, and to find yourself. (That’s) hard when you don’t even understand what’s going on in your own head.”

The REACT team developed the Mental Health Curriculum Report in 2014 detailing the need for mental health education for Grade 9 students, and launched a postcard campaign to urge a change in policy. An online petition collected about 3,000 signatures, and the campaign even got the attention of local politicians. The next year, White and the team got their wish – sort of.

Ontario launched a brand new HPE curriculum with a new focus on raising awareness of mental health among students and reducing stigma. Review of the HPE began back in 2007 and involved an extensive consultation process, says Ministry of Education spokesperson Gary Wheeler. Wheeler couldn’t confirm that Know Mental Health, No Stigma was considered in the new curriculum, but noted that many of the important issues raised in the teens’ report are now addressed in the revised HPE curriculum. White is happy to see they understand the importance of creating a social support network and socializing in the community.”

ATP gradually built a roster of more than 60 teen participants across Ontario, becoming a second home for many. The feedback has been all positive, Chan says, and the program has received rave – and sometimes tearful – reviews from grateful families. “I think (my son) feels enriched and more confident about himself (since going to ATP). He feels like he belongs. I think he found himself somewhat,” one parent says.

ATP also gives its volunteers the chance to make a difference and gain valuable experience. “It’s been really rewarding for me. I’m learning every week,” says Henry Chong, a York University graduate now working as a public health nurse for Durham Region. “It’s really applicable to my own practice as a nurse working in the community, learning how to build trust with all types of individuals.”

What started as a summer project has evolved into a growing not-for-profit organization, and Chan is its 23-year-old founding director. He was featured in Maclean’s magazine this year, spoke about autism at the Canadian Nursing Students’ Association’s national conference in 2014, and currently represents RNAO on the Ontario Working Group on Mental Health and Adults with Autism Spectrum Disorder – an interdisciplinary group of experts seeking to guide the province’s autism policy. And he accomplished all of this as a student with a full course load and a part-time job. “As a nurse, there are so many paths you can take,” Chan says. “It’s so great I went into a profession that gave me the skills I can use (for these projects).”

With the launch of the Kitchener-Waterloo chapter in June and more growth on the horizon, Chan has his eyes on the bigger picture. Maybe ATP – which operated in Toronto for less than $4,000 in its first year – could serve as a model for a national network of programs that increase access for families of autistic teens across the country. To help make this happen, he plans to create a “franchise manual” outlining the tools and procedures for establishing new ATP chapters.

Of course, none of this can happen without funding, and ATP got a lifeline in May, when the Laidlaw Foundation Youth-Led Community Change program awarded Chan with a $25,000 grant. He says the money will help take ATP to the next level. “I want to create a movement where students can take ownership of these programs...and have an impact in their communities,” he says.

At home in Scarborough, Chan sees his own community impact every week at ATP. And by his side, in charge of the food, is Joshua. “He absolutely loves it,” Chan boasts. RN

DANIEL PUNCH IS STAFF WRITER FOR RNAO.
Facing an intimidating new entry-to-practice exam, Adrienne Huston took to Twitter to lead her fellow nursing students through the challenge.

Her class was the first group of prospective Ontario nurses to take the National Council Licensure Examination (NCLEX) – which replaced the Canadian Registered Nurse Examination (CRNE) in 2015. Like the rest of her classmates, Huston was stressed out about studying for NCLEX, but she found some relief online.

Throughout nursing school, Huston followed health-care accounts and engaged nursing experts on social media, and says it really helped her understand the course material. An avid Twitter user since 2008, the 37-year-old mother of two was surprised to find most of her younger classmates at York University were not using the social media platform. “Why not use Twitter to make us less freaked out about NCLEX?” she thought.

Huston launched the @NCLEXvillage Twitter account and tweeted using the hashtags #NCLEX and #YorkU. She created an online community where students could trade resources and share epiphanies as they studied for the exam. While the campaign didn’t take off the way she had hoped, she’s glad to have helped some of her peers get out from under textbooks and connect online. She says nursing students are bombarded by messages that social media is dangerous (in terms of patient privacy violations). On the flip-side, they are not properly informed of the benefits of online activities.

Huston, who has since passed the NCLEX and landed a job at Newmarket’s Southlake Regional Health Centre, would one day like to teach first-year nursing students how to use social media professionally. “Nurses should use Twitter because... we need to reach out... and be a voice in society,” she says. RN

#FollowTheLeader

Being a leader doesn’t mean solving all the world’s problems. As Adrienne Huston shows, it can also mean taking charge to support your peers.

Facing an intimidating new entry-to-practice exam, Adrienne Huston took to Twitter to lead her fellow nursing students through the challenge.

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What does membership mean to you?

In celebration of our 90th anniversary, RNAO asked members to share their reasons for joining RNAO, and what it means to be part of their professional association.

I think the best part of being an RNAO member is having the opportunities for education. Whether you’re accessing the RNAO Advanced Clinical Practice Fellowships, the funding available through the Nursing Education Initiative, or the wide range of webinars; I feel RNAO really supports nurses in building and enhancing knowledge.”

MONICA GINN
CAMBRIDGE, ONTARIO

When I think about RNAO, I think back to nursing school. All of my professors would wear their gold RN pins with such pride, and tell students about how RNAO has these best practice guidelines (BPG) that will help us so much in our careers. I was in my second year and the idea of being on my own as a nurse was scary. I was in awe watching clinical instructors and nurses who mentored me. How did they get all this knowledge and not feel scared that they would make a mistake? And how could I get some of that? They kept saying: “Use the guidelines.” I didn’t really understand what that meant until my third year, when I had the opportunity to attend an RNAO conference. Nursing experts talked about how they had helped to develop a guideline, or how they implemented changes in their practice setting based on the BPGs. It was a light bulb moment for me. It really clicked that RNAO and the BPGs are tools for us to use that have real-world purpose for RNs in any practice setting. That conference is one of my best nursing memories to date. Fast-forward to my current nursing role, where I am in the midst of becoming a BPG champion. I would not have the confidence or knowledge I have today without the positive and early introduction of RNAO into my nursing life!

MEGHAN GRANSDEN
WINDSOR, ONTARIO

Being an RNAO member means that I am part of a larger community. Nursing is a profession that encompasses many settings, populations and areas of knowledge. RNAO brings together all of the skills, expertise and knowledge that Ontario nurses possess. We are an organization that believes in knowledge translation, advanced education, and supporting the nursing profession. It is truly an honour to be part of such a great profession and organization. RNAO has supported me through my pursuit of higher education, and provided support during my entire master’s degree.

ALIX DILWORTH
BRANTFORD, ONTARIO

I am so very proud of RNAO’s Best Practice Guideline (BPG) program. I have utilized several of the BPGs to guide my nursing practice, and have recommended several of them to my colleagues, nursing friends and health professionals in other fields of work. The guidelines are based on a rigorous assessment of the available scientific information and are updated as health-care changes and newer research redefine practice. These documents are readily available on the RNAO website, easy to locate, download, study, and integrate into clinical practice. Well done RNAO.

SUSAN BLATZ
TROY, ONTARIO

I’ve been a member of RNAO (on and off) since I was a student. I love that RNAO is a political force to be reckoned with. When I wasn’t a member of RNAO, I was living in England and they don’t have anything as amazing as this organization. And it shows. Nurses in the U.K. are still seen as failed doctors, or worse, handmaids to the doctors. Nurses are not respected like they are here, and I truly believe it is because of the amazing work RNAO does. I’m not a political person. Confrontation scares me. But I am so proud to be part of an organization that can fight with me, motivate me, and inspire me.

JULIA K. HARRIS
INGERSSOLL, ONTARIO

Being an RNAO member is very important in terms of being part of a shared professional voice in nursing. RNAO helps to represent us by continuously articulating our experiences in our ever-changing practice environments by defining/redefining best practices, trends, issues, roles and responsibilities when considering excellence in patient care. RNAO also provides us with an opportunity to be heard and to share our expertise provincially, nationally and globally; particularly when it comes to leadership, change and mobility. One example is the RNAO leadership course delivered to nurse executives in China. Having a collective voice in Ontario, along with connecting with nurses around the globe, affords us an ongoing ability to influence health, social determinants, and the overall global disease burden, locally and beyond. RNAO has been very effective over its lifetime in recognizing and being proactive in championing nursing and nurses.

JOANN ELIZABETH LEAVEY
LONDON, ONTARIO
I have been a nurse for 11 years. It was a long road to my diploma as a young single mother, attending nursing school and caring for a little one at the same time. I began my journey to my BScN part-time, working full-time while caring for my daughter. During my studies, I learned a lot about RNAO. I learned about its interest groups, its advocacy for our profession in the political arena, its best practice guidelines, and its support for nursing education. I utilized RNAO’s easily accessible website, applying for an education grant. I could not believe the warm welcome I received from RNAO. Everyone is professional and pleasant to interact with. RNAO is consistently on the frontlines, speaking out on behalf of our profession and supporting nurses in a variety of different ways. I admire that RNAO uses different forms of communication to reach out to nurses and the community, including: the website, automated phone messages, interest groups, print, webinars, emails, meetings, and more. RNAO also supports nurses who are not members, which I think is just as important as supporting members. Its evidence-based research and education funding information is proudly displayed on the website for anyone to access, regardless of membership status. RNAO also proudly supports new grads with free membership; getting new nurses off on the right track by providing access to a wealth of resources, job postings, mentors, and showing new nurses they are supported by their professional association. Over the last couple of years, I have had the opportunity to review RNAO’s resources as not only a member and workplace liaison, but also as a patient’s daughter. My dad was diagnosed with Atypical Alzheimer’s in October 2013, and has been in and out of hospital since then. I became frustrated at points, but organizations like RNAO provide encouragement and remind me that I have other nurses on my side to speak out on issues that I see while accessing our health-care system. RNAO is vocal on issues like nursing shortages, client-centred care, nursing models, enhancing medicare, and more. RNAO is an organization that puts nurses and patients first. It is an association that I am so proud to be a member of, and a workplace liaison for. Thank you RNAO for being an association that I can rely on as a patient’s family member, as a nurse, and as a member of the community. You are truly one-of-a-kind.

KERRIANNE THOMPSON
WHITBY, ONTARIO

As a professional and proud registered nurse, I find it so important to be part of a professional association that consistently advocates for nurses in Ontario. Maintaining that connection with fellow nurses through membership, chapters and interest groups is a vital part of ensuring I remain motivated and active when I strive to achieve excellence in nursing."

KATRINA OWEN
BARRIE, ONTARIO
Jobs, justice and climate change march

Thousands of people, including RNAO’s President-Elect Carol Timmings (above right, fourth from left) and Policy Analyst Anastasia Harripaul (below right), along with other RNAO members and health professionals, joined together at a rally on July 5 in downtown Toronto to call on the federal government not to pit the need for good jobs against action on a cleaner environment. The organizers said governments typically argue you can’t address both simultaneously. But those who took part in this summer’s march maintain it is both possible and desirable to strengthen both; our future depends on it. The event also featured appearances by American activist Jane Fonda, environmentalist David Suzuki, author Naomi Klein, and representatives of First Nations communities. RNAO will continue to urge action on this with all political parties as we approach the federal election in October. Stay tuned.

Making the case for a national pharmacare plan

RNAO has joined a coalition of health organizations to step up demands for a national pharmacare program. The association took part in a media conference on June 18 to press Canada’s political party leaders to address this issue in the coming federal election. In addition to RNAO, the Campaign for National Drug Coverage includes Canadian Doctors for Medicare, the Canadian Association of Community Health Centres, the Association of Ontario Health Centres, and the Canadian Federation of Nurses Unions. The coalition has set out to remind decision-makers that Canada is the only developed country with a universal health system that does not provide universal coverage for medications.

A recent poll conducted by Angus Reid reported that a quarter of all Canadian households say access to prescription drugs, and affordability, are important to them. The lack of a national plan results in uneven access to essential medications and runaway drug costs.

RNAO says a fully funded drug plan could save Canadians at least $7 billion. An action alert, asking politicians to commit to such a plan, was issued in June, and almost 900 people have signed.

You can have your say by visiting www.RNAO.ca/pharmacareAA. For more information about the coalition’s work, visit www.campaign4nationaldrugcoverage.ca

RNAO applauds new regulations on pesticides

New rules curbing the use of neonicotinoid pesticides came into effect July 1. RNAO was among a number of groups that lobbied the ministry of environment to implement regulations governing the use neonics, considering the harm they cause to bees and other pollinators such as butterflies and certain bird species. The Ontario Beekeepers’ Association says corn and soybean seeds coated with neonics have been largely to blame for a significant drop in bee colonies. RNAO teamed up with Canadian Physicians for the Environment and the David Suzuki Foundation in calling for action, holding numerous meetings with government staff, including Environment Minister Glen Murray. The changes reduce the number of hectares farmers can plant the pesticide-coated seeds by 80 per cent, making Ontario the first jurisdiction in North America to do so. RN
Jumpstart your savings.

We know how busy you are and that you probably don’t have time to shop around for insurance. So we’ll do it for you – for free.

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Consultations with members about new leadership structure

As shared with members at the February assembly meeting and April 2015 AGM, the board of directors (BOD) is considering updates to its current structure, which has not been revised for more than 40 years. To this end, the board wishes to consult with its members and hear your perspectives.

Consultation sessions have been scheduled for the next five months. These consultations will shape the board motions and necessary bylaw changes (if any) which will be brought to the One Member, One Vote at the 2016 AGM. Members will have the final say on the final board composition.

Issues to be discussed for a revised BOD structure include:
- Incorporation of one student representative (currently none)
- Incorporation of one public representative (currently none)
- Incorporation of one additional interest group chairs representative (currently, there is one)
- Incorporation of the domains of expertise of member-at-large (MAL) roles into the regional representative roles
- Deletion of MAL roles
- Changing BOD terms of office limit from two to three years, with no renewal (currently, the term is two years, with one-time renewal)

Consultation Dates:
Aug. 18, 12:00–1:00 p.m., and Aug. 20, 6:00–7:00 p.m.
Sept. 28, 12:00–1:00 p.m., and Sept. 30, 6:00–7:00 p.m.
Oct. 20, 12:00–1:00 p.m., and Oct. 21, 6:00–7:00 p.m.
Nov. 16, 12:00–1:00 p.m., and Nov. 18, 6:00–7:00 p.m.

To register, visit www.RNAO.ca/consultation2015

“On behalf of the board, I look forward to engaging with members on these important considerations that will shape the future of the RNAO board structure.”
Carol Timmings, President-Elect and Chair, RNAO Governance Committee

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IN THE END  BY JACQUELINE HANLEY

What nursing means to me...

AFTER RETURNING HOME FROM A SHIFT RECENTLY, my husband asked me: “How was your day?” How could I possibly share with him what it was really like? How could I share the conversation I had with a six-year-old, mature beyond her years? Or the feeling I had when she told me she hates her scars? How could I express how weary I felt at the end of the day; a day that wasn’t even particularly busy?

My mind filled with thoughts of what a typical day as a pediatric nurse is like, and I wished that when asked about it, I knew how to give a truthful answer. I wished that I could really express what a shift is like, and know I would be understood.

If I were to explain truthfully, I might start off with how many times I saw a child smile. I might tell you the tears I wiped. I could tell you about the kids I made laugh, and the kids I made cry.

I might tell you about the parents I consoled, reassured, encouraged; the family that thanked me, and the family that pushed me away.

I might tell you how many times I grew frustrated, or thought my headache couldn’t get any worse.

I might tell you how I taught a new nurse, and how I learned from an old colleague.

I might tell you about the stickers I stuck, the pages I coloured, and the teddy bears I tucked into bed.

I could tell you about the call bells that rang; the IV pumps that beeped; the monitors that alarmed.

I could tell you about the blood product reactions, the worrisome fluid balances, or the child who was fine, and then suddenly, wasn’t.

I could tell you about the tricks I used to assess a three-year-old; the games we played so he would take his meds; and how, in order to auscultate a five-year-old’s chest, I had to pretend to listen for monsters.

If I were to tell you what each day is really like, I might tell you how funny it is to hear a two-year-old say “stethoscope,” and how heartbreaking it is to hear a child whisper, “I just want to go home.”

I might tell you that today I saw a child’s first steps. Or watched a preemie finish her first whole bottle. I might tell you about the father who fed her, who took this small victory as a sign of hope.

I might tell you the bravest person I know is an eight-year-old, and the happiest, a two-year-old with a medical history as old as she is.

I might tell you how many times I felt my heart break.

If I could really talk about my day, I might tell you about the decisions I made. The priorities I set. Or about my “nurse’s intuition” that told me when I should be concerned.

I could tell you about the orders I
questioned. The orders I should have questioned. The split second decision I made. The carefully calculated words I chose. I could tell you how I fought for my patient. I could tell you how my patient fought me.

I could talk about how I taught a parent to be the nurse to their child that they never wanted to be.

I could tell you how that parent taught me about hope.

I could tell you about the moments of panic. The moments of empowered confidence. How smoothly our team functioned. How resourceful we can be.

I’d want to tell you about the breaths we gave; the lives we saved; the lives we couldn’t save.

I might share with you those moments when I just didn’t know what to say. Or the times I realized there was nothing I could say. I could tell you how often we see a child suffering and think maybe enough is enough. I could tell you about the times we think “everything” will never be enough. I would struggle to tell you how hard it is to say goodbye. I’d have a harder time telling you how sometimes saying goodbye can be a relief.

I might tell you how many times I thought, “This isn’t easy.”

I could tell you about the times I feared that when I have children of my own, they might not be healthy. Would my husband and I be like the families I meet here? How would we make it through?

I could tell you how I know I probably won’t spend my career at the bedside, but how much I know I’ll miss the bedside when I finally walk away.

I could talk about these things, if I thought I might be understood. Instead, when asked about my day, I’ll say “It was good,” with a smile; “I’m tired,” with a yawn.

Being a nurse is one of the hardest things I’ve ever chosen to do. It challenges me. It inspires me. It exhausts me. It empowers me. And I love it.

It may sound cliché, but when I’m tired and worn, I try to gather the strength and bravery of that eight-year-old and the happiness of that two-year-old. Maybe next time, when someone asks, I’ll smile, yawn and say, “It was...indescribable.”

Jacqueline Hanley is a Clinical Nurse Specialist, Acute Pain Service, and an RN on the Multi-Organ Transplant Unit at Toronto’s Hospital for Sick Children (SickKids). This is an edited version of an article that appeared in The Toronto Star, April 2014.

Drop us a line or two
Tell us what nursing means to you.
Email editor@RNAO.ca
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