

REGISTERED NURSE JOURNAL

A man with dark hair, wearing a dark blazer over a light-colored button-down shirt, is sitting in a lecture hall. He is leaning forward with his hands clasped on the wooden desk in front of him. The lecture hall has rows of blue seats and wooden railings, and the background is slightly blurred.

An alternate path to RN

At the heart of most transitions
from RPN to RN is the desire
to do more for patients.



RNAO

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

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of patients

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EARLY BIRD PRICES (by May 2, 2017)

RNAO member – \$1977.50

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REGULAR PRICES (after May 2, 2017)

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Non-member – \$3022.75

all prices include HST

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COVER: As an RPN, Hetal Patel was encouraged by peers to pursue his RN degree. He says there were many challenges, but he pushed through to realize his goal of one day becoming an ICU RN.

The journal of the REGISTERED NURSES' ASSOCIATION OF ONTARIO (RNAO)

158 Pearl Street
Toronto ON, M5H 1L3
Phone: 416-599-1925 Toll-Free: 1-800-268-7199
Fax: 416-599-1926
Website: RNAO.ca Email: editor@RNAO.ca
Letters to the editor: letters@RNAO.ca

EDITORIAL STAFF

Marion Zych, Publisher
Kimberley Kearsey, Managing Editor
Daniel Punch, Writer
Victoria Alarcon, Editorial Assistant

EDITORIAL ADVISORY COMMITTEE

Laryssa Bilinsky, Una Ferguson, Rebecca Harbridge,
Elizabeth Kerr, Maria Rugg

ART DIRECTION & DESIGN

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ADVERTISING

Registered Nurses' Association of Ontario
Phone: 416-599-1925
Fax: 416-599-1926

SUBSCRIPTIONS

Registered Nurse Journal, ISSN 1484-0863, is a benefit to members of the RNAO. Paid subscriptions are welcome. Full subscription prices for one year (six issues), including taxes: Canada \$38 (HST); Outside Canada: \$45. Printed with vegetable-based inks on recycled paper (50 per cent recycled and 20 per cent post-consumer fibre) on acid-free paper.

Registered Nurse Journal is published six times a year by RNAO. The views or opinions expressed in the editorials, articles or advertisements are those of the authors/advertisers and do not necessarily represent the policies of RNAO or the Editorial Advisory Committee. RNAO assumes no responsibility or liability for damages arising from any error or omission or from the use of any information or advice contained in the *Registered Nurse Journal* including editorials, studies, reports, letters and advertisements. All articles and photos accepted for publication become the property of RNAO. Indexed in Cumulative Index to Nursing and Allied Health Literature.

CANADIAN POSTMASTER

Undeliverable copies and change of address to:
RNAO, 158 Pearl Street, Toronto ON, M5H 1L3.
Publications Mail Agreement No. 40006768.

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Carol Timmings, RN, BScN, MEd (Admin)
President

Vanessa Burkoski, RN, BScN, MScN, DHA
Immediate Past-President

Doris Grinspun, RN, MSN, PhD, LLD(hon), O.ONT
Chief Executive Officer, ext. 206

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EDITOR'S NOTE KIMBERLEY KEARSEY

Baby steps

I'VE ALWAYS ENVIED ANYONE WHO knew early in life what type of career they wanted to pursue. Nurses often tell me they knew when they were kids the direction their professional lives would take them. I have always loved to write, but it wasn't until my mid-20s that I realized it could be a career. When I did, there was no turning back. The more I thought about it, the faster I wanted to get on with it.

For many RPNs, that is the thinking behind their decision to go back to school for their baccalaureate degree (see page 12). They want to advance in the profession they love. It's a bold move given they are usually older and have more responsibilities with families and mortgages. But it's a move they commit to, despite the challenges.

There's a lot to be said for that kind of drive. It overshadows any fear or reservation these nurses might have about making a change. Fortunately, that drive almost always takes individuals to a place they know in their hearts they want to be.

Our RN profile in this issue is Yvonne Heath (page 7). She too followed her heart later in her career, wrote a book about

preparing for the end of life, and is spreading her message. Her passion to convince people about the importance of having honest conversations about end-of-life is something that took some time to grow, but once it blossomed, there was no turning back. Heath's story is another example of knowing where you want to go, and taking the necessary – albeit sometimes difficult – steps to get there.

Passion is the catalyst for many important movements, and our feature about Kerrie Pickering, and her push to educate peers on the role nurses play in keeping our water supply free from pharmaceutical waste (page 26), is yet another example. It only takes a few extra moments to dispose of waste properly, to explain to a patient or client that their unused medications should go to their local pharmacy, or to review workplace policies on the various disposal bins and how to use them. Of course, nurses are just one piece of the safe water supply puzzle, but every step counts.

And, as they say, nobody ever gets anywhere without those first few baby steps. **RN**





Nurses lead change through eHealth technologies

THE FAST PACE OF CHANGE IN OUR increasingly digital world is forcing everyone to re-think how they approach their work. Nursing is no exception. Now, nurses and other health professionals have a new resource to help them adapt.

In February, RNAO released a new best practice guideline (BPG) titled [Adopting eHealth Solutions: Implementation Strategies](#). Its 26 evidence-based recommendations, developed in partnership with Canada Health Infoway, provide implementation strategies that can help ensure our country's health system better adapts to the evolution already underway, and to the changes on the horizon. In my role as chief nursing officer with Toronto Public Health, I have been co-leading the business side of designing and implementing a community health information system for nurses and other professional staff. I am confident RNAO's BPG will be an enormously helpful tool for our organization.

New technologies have the potential to increase efficiency, improve patient safety, and result in better health outcomes. And yet, research shows 70 per cent of eHealth projects undertaken in organizations fail due to leadership shortfalls. This includes: insufficient planning, little change in management, and lack of buy-in.

At the heart of this change is how we, as nurses, engage. Some of you may worry about how a greater reliance on

technology will affect your interactions with patients and clients. Losing the so-called "sounds and touch" of nursing as one nurse described it. The impact on the therapeutic relationship is a valid concern. But that shouldn't deter us from the potential gains that await.

The fact is technology is already transforming health care. Examples include:

electronic medical records, mobile devices, e-counselling, virtually observed therapy, and remote patient monitoring systems, just to name a few. Yet, despite the millions of dollars invested in bringing various health information systems together, we still are not connected the way we can and should be. Technology is key to supporting a whole system approach and to safely sharing important data that will result in improved population health planning and better access to care.

That's why this BPG is important. Strong leadership at all levels of the health system is also crucial. Among the BPG recommendations is the creation of specialized chief nursing information officers (CNIO), considered critical if we want to advance clinical adoption.

Also important is a

recommendation that health organizations establish formal structures that engage health executives, clinicians, and patients through the various steps of implementation. Education and training must be part of the eHealth infrastructure in all health organizations and academic institutions. Nurses and other health professionals should also

providers deliver the integrated care Canadians expect. Key to moving from concept to reality is making sure providers and their patients are engaging in designing and adopting eHealth solutions, leaving no one on the sidelines of change.

There is no end to the change and convenience technology can bring to our work. Wireless systems give nurses the

"TECHNOLOGY IS CHANGING THE WAY WE PRACTISE, MANAGE AND PROTECT THE INTEGRITY AND PRIVACY OF PERSONAL HEALTH INFORMATION, SAVE TIME, AND AVOID ERRORS."

assume responsibility for being up-to-date on role-specific eHealth competencies.

Ensuring nurses are part of this change is essential. It's one of the best ways to take stock of how technology is and will continue to change the way we practise, manage and protect the integrity and privacy of personal health information, save time, and avoid errors. But we also must ensure new advances in technology are not burdensome. The changes must not affect the therapeutic relationships we have with our patients and clients.

Technology has enhanced so many aspects of our private lives and we can and should expect similar advances in our health system. This can enable improved communication within and between sectors and services. Provincially, and right across Canada, effective eHealth systems can help

freedom to move around without the worry of being tied to workstations. Technology is a tool that allows for timely point-of-care interactions and real time connections to patients and clients.

Technology is here to stay and its prevalence in nursing and in the health system will continue to grow. Leaders in all roles and sectors must buy in if Canada wants to achieve its eHealth goals. And it's up to us as nurses – from frontline staff to administrators, educators, researchers, and policy makers – to ensure we're fully involved in designing and implementing these new technologies. By doing this together, we optimize the present and help to shape the future of our daily practice. **RN**

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



Less talk, more action: Continuing our push for improved indigenous health

WHEN THE FEDERAL GOVERNMENT released its budget in March, it committed \$828.2 million over the next five years to improve health outcomes for Canada's Indigenous Peoples. This is part of a broader commitment to infrastructure and health investments that are meant to improve the socio-economic conditions of Canada's First Peoples.

Given RNAO's strong and ongoing advocacy on the issue of indigenous health, this funding is promising news. However, there's no mistaking the view we share with so many other advocates working to right the wrongs of the past: it is simply a drop in the bucket.

A few years ago, I participated in a Nursing Week visit to a First Nations community. I wanted to visit the north to wake myself up to the realities of life on a reserve. I had heard of the hardship, but I needed to see it for myself in order to truly understand.

I visited the home of a grandmother who had a house full of children whose mother was in jail. The kitchen cabinets were tied with plastic bags so the little ones could not open them. "They are full of mold," she said as she opened one to show me. It was a tiny home and there were clothes everywhere because they lived in every available space. There were buckets in every corner of the fully occupied basement, catching water as it dripped, and creating moisture that left even more dangerous mold on the

walls and ceilings. No more than a 10-minute walk from the front steps of this grandmother's home, there was the garbage dump for the community. It was an open field, much like the troubling dumps I had seen while visiting developing countries. As a nurse, I gasped at the public health risks.

When I left the reserve that day, I was devastated. My visit

"OUR EFFORTS AT RNAO TO MAKE A MEANINGFUL CONTRIBUTION TO IMPROVED INDIGENOUS HEALTH HAVE TAUGHT US SOME VERY IMPORTANT LESSONS, BUT THERE IS STILL SO MUCH MORE TO LEARN AND DO."

left me wondering why more people have not seen life on a reserve first-hand. Why haven't more people witnessed this travesty right here at home. Perhaps more visitors might mean more action.

It's been two years since the [Truth and Reconciliation Commission of Canada released its recommendations to repair the harm caused by residential schools](#). Much work has followed, including the important advocacy work of Cindy Blackstock, executive director of the First Nations Child and Family Caring Society of Canada. Blackstock is outraged the federal government has not complied with a Canadian Human Rights Tribunal ruling that it imple-

ment Jordan's principle — named for a five-year-old boy who died in hospital in 2005 as the federal and Manitoba governments squabbled over who should cover the costs of his health care.

Prime Minister Justin Trudeau announced last July that \$382 million would be invested over three years to help First Nations children, but this

too is a drop in the bucket, especially when you consider tragedies continue on reserves. In Wapekeka First Nation, two 12-year-old girls died by suicide in January. How is this providing hope for other indigenous youth? And, what will it take to have mental health and addiction services readily available — on site and ongoing — given that we know the need is desperate.

The health of Canada's indigenous peoples is a priority for RNAO. The association partnered with the Canadian Indigenous Nurses Association (CINA) in February to co-host a webinar to discuss how to build partnerships that advance nursing policy, research, practice, and education goals

while respecting indigenous cultures, philosophies and right to self-determination. We also hosted a panel discussion at our February assembly meeting about the colonial nature of Canada's health system.

As we approach this year's AGM, we look back at an important keynote presentation at last year's AGM, which focused on the challenges and opportunities linked to health and well-being of Ontario's First Nations peoples. That presentation preceded the signing of a formal letter of intent between RNAO and the province's Regional Chief Isadore Day to work together to address the physical, mental and spiritual health needs of Ontario's First Nations.

Our efforts at RNAO to make a meaningful contribution to improved indigenous health have taught us some very important lessons, but there is still so much more to learn and do. I urge anyone who says they believe in reconciliation to visit Indigenous Peoples on their own turf, and listen to their needs. It's only through these visits, and looking into the eyes of those who have been hurting for centuries, that we will finally shift from rhetoric to action. And from pain to healing. **RN**

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

Follow me on Twitter
@DorisGrinspun

Learning to let go

RN-TURNED-AUTHOR YVONNE HEATH HELPS OTHERS UNDERSTAND THE IMPORTANCE OF END-OF-LIFE PLANNING.

RN YVONNE HEATH REMEMBERS the day she came across a woman in her 60s while working at a chemotherapy/infusion clinic in central Ontario. She could not believe what she was seeing. The woman was short of breath, and her feet, legs and abdomen were swollen as she waited to be seen, unaware she was nearing the end of her life. “She wasn’t even going to make it through her next chemotherapy treatment,” says Heath, who, after 27 years of nursing, saw the signs. Heath called the woman’s oncologist to confirm she was not told of her condition. She found out the oncologist was not good at discussing death.

“I was devastated because I naively believed that every oncologist should and would be great at having these brave and honest conversations,” she says.

Heath told the woman the reality of her situation and encouraged her to ask her doctor about her options in terms of palliative care. She answered the woman’s questions and reassured her that she would receive the best care possible. Within two weeks of that visit, the woman died at home.

“That was an eye-opener for me,” Heath admits, saying the encounter in 2014 made her realize just how ill-prepared many health-care professionals are to have those difficult conversations with their patients, which can result in

excessive suffering.

Looking back, that experience, coupled with a career full of similar experiences, set her on the path to write a book about how to embrace death, and how to approach conversations about end-of-life wishes,



quality vs. quantity of life, and tips for self care. [Love Your Life to Death](#) was published in 2015 and includes the stories of patients Heath has met, and what they have taught her.

Heath graduated from the nursing program at Centennial College in 1987. Over the past 30 years, she has worked in several hospitals and health-care organizations in Canada and the U.S. Her first position was at Toronto East General Hospital (now Michael Garron Hospital) on the medical unit in 1988, where she cared for patients with chronic diseases. Within a few years, Heath relocated to the U.S., where

she worked for the Roswell Cancer Institute in Buffalo, then became a traveling nurse in Louisiana before moving back to Canada and working at Huntsville District Memorial Hospital in 1997. She says that during this time she saw

was able to cope with her child’s death. She learned it was because Kevin took the time to speak openly about his fate, and what he wanted the end of his life to look like. The experience made her realize that we all need to talk about death more openly.

Heath was still working in chemotherapy when she accepted a job at the South Muskoka Memorial Hospital in 2010. Despite knowing how important it is to talk about end-of-life, she noticed many patients and families still were not having those conversations.

“One thing after another just kept confirming I needed to do something,” she says about the push to begin writing her book.

In 2015, Heath put her nursing career on hold to promote the book and raise awareness of her message. She also works as an inspirational speaker and host for Rogers TV, interviewing people she says are grieving well, living well and dying well. Her goal is to spread her message beyond her home province in hopes of changing the way we view death in society.

“My big message is to empower communities and professionals to live life to the fullest, learn to grieve and support others, and have “the talk” about end-of-life long before it arrives,” says Heath. This will help “...to diffuse the fear.” **RN**

Three things you didn't know about Yvonne Heath:

1. She is inspired by American physician, comedian, clown and author Patch Adams.
2. She is married to a paramedic who is 13 years her junior.
3. She dreams about sharing her message with TV personalities Ellen Degeneres and Oprah Winfrey.

patients suffer anxiety and fear because they avoided discussing death.

In 2001, when she was offered an opportunity to cover a maternity leave in the chemotherapy clinic, Heath saw first-hand the benefits of having an end-of-life care plan for patients and families.

At the clinic, she met a patient named Kevin, a man in his 40s who had gone through chemotherapy for two years. He knew he was nearing the end, and Heath recalls his gracious and positive attitude right up until his death.

After he died, she spoke with his mother, asking how she

VICTORIA ALARCON IS EDITORIAL ASSISTANT FOR RNAO.

NURSING IN TH



Northumberland RN Michelle Verbeem (right) was one of 10 health professionals to visit Guatemala as part of a child health project in February.

Ontario nurses, midwives learn about health care in Guatemala

Woolsey and Cobourg Clinic RN **Michelle Verbeem** works with midwives on a daily basis, and was thrilled to have the opportunity to visit an area of the world where the midwife is the traditional birth attendant. As part of Horizons of Friendship's Maternal, Newborn and Child Health project, the Northumberland chapter member travelled to Totonicapan, Guatemala in February to learn about the care of infants and newborns in a place where resources and transportation are extremely limited. "One of the midwives told us she travels two hours to visit one of (her clients), up and down hills, through ravines, past dogs – it was very eye-opening," says Verbeem. Seeing how Mayan midwives engage with babies, Verbeem learned they rely a lot on sight and touch. "They look at the eyes (of babies). They look at the colour to make sure they're not yellow. They look at the fingers and toes to see if they are swollen. And they feel the baby," says Verbeem. As part of the project, a small group of Guatemalan health professionals – two doctors and three traditional Indigenous midwives – visited Ontario in March. ([Northumberland Today](#), March 15)

RN prescribing coming soon

For easier and faster access to high-quality health care, the Ontario government will soon authorize registered nurses to prescribe certain medications independently. "By taking this tremendous step, we're making history," says RNAO CEO **Doris Grinspun**. At RNAO's 17th annual Queen's Park Day on Feb. 23 (see more on page 17), Health Minister Eric Hoskins announced he will introduce proposed amendments to the *Nursing Act* this spring so that RNs will have the authority to prescribe certain drugs for non-complex

conditions, and to communicate a diagnosis for the purpose of prescribing. "It will enable nurses to provide a full contribution to the health and health care of all Ontarians," says Grinspun. Along with giving RNs the authority to prescribe independently, the Ontario government has also promised to authorize nurse practitioners to prescribe controlled substances. "Now registered nurses and nurse practitioners can become a huge solution to health-care access issues, not only for people, but for complications and system ineffectiveness," says

Grinspun. There are currently 96,004 registered nurses and 2,657 nurse practitioners practising in Ontario. ([Etobicoke Guardian](#), March 8)

Speaking out for oral health care

The Chatham-Kent Board of Health and Chatham-Kent Public Health Unit are urging the provincial government to adopt dental coverage (for adults and seniors) as part of basic health-care coverage through OHIP as soon as possible. **Stacy Rybansky**, program manager with the Chatham-Kent Public Health Unit, says she gets calls every

day about dental health, often from seniors. "It is something the community needs," she says. Currently, the province only covers dental until children turn 17, leaving many without access to important oral care services if they are not covered under their own dental plan. "We know that 61,000 Ontarians do not have access (to preventive dental care), most likely due to barriers of cost," adds Rybansky. The public health unit is advocating for preventive care in an effort to delay or reduce the need for treatments such as tooth extraction due to decay or more serious issues. To move this

E NEWS

BY VICTORIA ALARCON

Letter to the editor

*In response to the Haldimand-Norfolk Health Unit cutting an NP position, RNAO President **Carol Timmings** writes a letter to the [Simcoe Reformer](#) about how the decision will affect vulnerable populations in the community. (Feb. 21)*

Putting health needs first

News that the Haldimand-Norfolk Health unit has plans to cut a nurse practitioner position is deeply troubling. The action taken by the health unit runs counter to the values of putting people and their health needs first, especially for vulnerable populations. Women in the communities of Haldimand and Norfolk deserve to have more access, not less, when it comes to health services, in particular, quality prenatal and postnatal care. Increasingly, people who live in rural areas of our province are frustrated by the lack of timely access to health services due to shortages of doctors and other providers. This is why we urge the health unit to rethink its decision and we urge members of the local council to intervene.

Letter to the editor

RNAO Region 6 board representative Hilda Swirsky writes a letter to the [Toronto Star](#) following the publication of an article (March 15) about air pollution causing health concerns. The letter is a reminder of the detrimental effects of air pollution on everyone's health, and especially for children and people with heart or breathing problems.

Air pollution causing concern

Toronto has come a long way to shed its reputation as the "Big Smoke" but we have to keep striving for cleaner air to ensure a healthier city.

The World Health Organization has declared air pollution a carcinogen. The quantity of pollutants in the air, coupled with exposure time, increases the adverse effects of air pollution on our health. Children and people with heart or breathing problems are particularly at risk. The Air Quality Health Index is an empowering tool, located in the weather section of every issue of the *Toronto Star*. It measures the same three pollutants identified in this article (Despite gains, Toronto's air pollution still causing serious health problems) and is designed to help you protect yourself and your family by limiting exposure to air pollution.

Everyone, especially vulnerable people, can stay vigilant by watching this index, and reducing or rescheduling strenuous outdoor activities if they experience symptoms.

As a city, we should also opt for public transit, car-pooling, cycling or walking whenever possible to improve health outcomes.

agenda forward, the board of health is looking for support from the Association of Local Public Health Agencies when it holds its annual meeting in Chatham-Kent later this year. ([Chatham This Week](#), Feb. 16)

Ministry of Health and Long-Term Care. The program screens the average-risk patient who has no family member (parents, siblings, or children) with a history of colorectal cancer, and is showing no symptoms themselves.

Nurses and other providers wear blue to raise awareness

Marking Colon Cancer Awareness Month in March, Woodstock Hospital staff wore blue to show their support for various screening methods, including the Registered Nurse Flexible Sigmoidoscopy (RNFS) program. **Christine Blum** is co-ordinator, educator and endoscopist for the RNFS program, which launched in 2007 with support from Cancer Care Ontario and the



Staff at Woodstock Hospital mark Colon Cancer Awareness Month by wearing blue.

NURSING IN THE NEWS

“To be eligible for RNFS, patients must be 50- to 74-years-old,” says Blum, adding they need to also be due for colon screening. Since 2014, the Woodstock Hospital has screened 272 patients. There are other hospitals in Ontario that offer the program, such as Hamilton Health Science Centre, which screens approximately 400 patients annually. To find out more about the program and screening for colon cancer, visit cancercare.on.ca/pcs/screening/coloscreening/RNFS. (*Woodstock Sentinel-Review*, March 7)

Giving homes to those in need

The city of London is making a difference in the lives of female sex workers thanks to its Street Level Women at Risk (SLWAR) program. Through the program, women who are homeless and entrenched in the sex trade find homes so they can better tackle the many problems that come from years of battling poverty, illness, violence, addiction and trauma. “If we can help women gain stability so they can have their children with them in a safe environment with appropriate supports, we are actually

affecting the health of their children and their children’s children,” says **Heather Lokko**, an RNAO member and chief nurse for the Middlesex London Health Unit. This is “society-changing” work, she adds. The program employs a care co-ordinator, housing selection worker, and nine housing stability workers from different agencies. The women in the program are not required to make commitments to get clean or leave sex work to get or keep a home. They are considered a community member who deserves a home, and a place

they can feel safe and receive support. Since the 2016 launch of the program, 26 women have found homes. According to London police, there are about 155 women involved in the sex trade in that city.

(*London Free Press*, April 3) **RN**

Have you called a reporter to talk about a health or nursing issue in your community?

Have you invited a journalist to cover your local event?

Tell us about it at editor@RNAO.ca. We may feature your story here.

OUT AND ABOUT



ENGAGING PATIENTS TO ENSURE THE BEST CARE

RNAO’s Patient and Public Engagement (PPE) Advisory Council met for the first time on March 25 to set expectations for the group’s work in the months ahead. The PPE strategy was launched in October 2016 with an invitation to public partners to engage in conversations about their experiences with the health system, and what improvements are needed to ensure patient-centred care. (From left) RNAO IABPG Director Valerie Grdisa and project co-ordinator Glynis Gittens alongside council members Mark O’Gorman, Sol Mamakwa, Mae Katt, co-chairs Janet Roberts and Sholom Glouberman, Brian Clark (back), Susan Gapka, RNAO CEO Doris Grinspun, and IABPG Associate Director Michelle Rey.



BPSOs SHARE STRATEGIES, SUCCESS STORIES

Each year, leaders from RNAO’s Best Practice Spotlight Organizations (BPSO) come together to share strategies and success stories as they work to implement best practice guidelines (BPG) across all sectors of Ontario’s health system. This year’s meeting, which took place on March 7, included interactive poster presentations from across the province, including this presentation by Melissa Donskov (left) on behalf of BPSO pre-designate Residence Saint-Louis Bruyère, a long-term care facility in Orléans.

NURSING NOTES

RNAO begins work on end-of-life BPG

Members of RNAO's end-of-life best practice guideline (BPG) panel met for the first time on March 29, beginning discussions about the guideline's scope, preparing for the systematic review, and determining next steps. The panel will be co-chaired by Lesley Hirst (second from right), chief of nursing practice, Hamilton Health Sciences, and Christine McPherson (inset), associate professor in the School of Nursing, University of Ottawa. Working with the panel are RNAO staff (left to right) Grace Suva, IABPG program manager, Michelle Rey, IABPG associate director, and Valerie Grdisa, IABPG director. To find out more about this and other BPGs in development, visit RNAO.ca/BPG



Nursing researcher appointed to the Order of Ontario

Long-time RNAO member Cheryl Forchuk has been appointed to the Order of Ontario in recognition of her research and ongoing work on homelessness, poverty and mental health. A one-time recipient of RNAO's Leadership Award in Nursing Research, Forchuk says she is honoured. "It is particularly exciting because mental illness and homelessness are issues that haven't always been on the public's radar. I've seen this changing over the last few years, which means there is hope for more progress," she says. Forchuk has always worked towards progress in the care offered to some of the province's most marginalized populations. She is the pioneer behind Ontario's transitional discharge model, which ensures

psychiatric clients are not discharged from hospital without being connected with a community care provider and a peer who has successfully integrated into the community after a psychiatric diagnosis. The model, which has been found to dramatically improve outcomes, reduce hospitalizations, and improve clients' quality of life, is one of many initiatives for which Forchuk is being recognized. "We at RNAO have always been proud of Cheryl for advancing the health needs of persons with mental illness, and especially those who are also homeless," RNAO CEO Doris Grinspun said following the announcement of Forchuk's investiture. "Cheryl truly embodies nursing leadership through all she has accomplished and the difference she has made," added RNAO President Carol Timmings. Forchuk will receive the honour at Queen's Park in June.

RNAO welcomes new policy director



In April, RNAO welcomed its new director of nursing and health policy, Lisa Levin, who joins the executive team with vast experience in policy, service delivery and communications. "I am so excited to join RNAO and help to shape nursing and health policy and advocacy," Levin says. "This role gives me the opportunity to advance the role of nurses, who are such critical players in health care, and also to improve the social and environmental determinants of health for all Ontarians." For the past two years, Levin was principal consultant with Lisa Levin and Associates, where she provided policy and

strategic planning advice to a range of health and community care organizations. Prior to that, she spent 10 years in senior executive positions with Circle of Care, a non-profit home health care and community support agency, where she led portfolios including communications/marketing, volunteers, community development, service integration and home services. From 1991 to 2005, Levin held policy advisor roles for various government ministries, including health and long-term care, community and social services, housing, and children's services. She is also a committed community volunteer, sitting as chair of the Ontario Caregiver Coalition, founder and former lead for the Ward 10 Emergency Roundtable in Toronto, and advisory committee member for the Neshama Hospice. **RN**

Building bridges

Nurses say making the transition from RPN to RN offers as many rewards as it does challenges.

BY DANIEL PUNCH

**PHOTOGRAPHY BY
ETHAN HORST MITCHELL
AND STEFANIE NEVES**

Jennifer Bilbie was 17 years into her career as an RPN, fulfilling a lifelong ambition to work in long-term care, when a dying woman inspired her to shake things up.

Becoming an RN had always interested Bilbie, who hoped to care for her patients more completely. But she was happy in her job as an RPN at Extendicare London, where she had worked since 1997.

It was the 2013 holiday season, and Bilbie was caring for Ruth*, a long-term care resident who was very ill with congestive heart failure. The two became close, and Ruth noticed Bilbie's leadership qualities, clinical judgment, and how much she cared for each and every one of the home's residents. Shortly before her death, Ruth made Bilbie promise to go back to school so she could take on a larger role in health care. "It was one of the last promises I made to her, so I'm making good on (it)," Bilbie says.

She enrolled in Trent University and George Brown College's collaborative RPN-to-BScN bridging program the following year. The three-year program is one of 11 bridging programs in Ontario – encompassing seven universities and 11 colleges – that build on the skills of RPNs as part of an abbreviated path to become an RN. Since the province's first bridging program opened at the University of Ontario Institute of Technology (UOIT) in 2003, these programs have attracted diploma-educated RPNs at all stages of their careers who are looking to broaden their scope of practice.

* A pseudonym has been used to protect privacy.



Jennifer Bilbie (left) began the transition from RPN to RN to fulfill a promise to Ruth*, a dying patient. Just as Bilbie was considering dropping out of the program, she got a call from Ruth's husband (right), checking in on her progress. The call was the motivation she needed to continue.



“I feel more confident as a nurse that I can do multiple things.”

– HETAL PATEL

the sacrifices Bilbie made are common among bridging students. “Many of them are putting many elements of the security of their lives at risk going back to school. This is...a big leap.”

Coffey says bridging students come from all walks of life, but they usually enter their program with multiple personal, professional and financial commitments. Her research found that many of them work more than 24 hours a week during their studies, but have incomes below the poverty line. And more than half are supporting a dependent child or parent. Yet Coffey says they persevere because they want to make a difference. “These are people who are incredibly committed to nursing, and it shows,” she says. “They are not just dipping their toes in the water...they know what nursing is all about.”

The academic intensity is also a challenge for students in the first year of bridging programs. A 2015 systematic review, [Bridging the gap in RPN-to-RN transitions](#), found bridging students are often surprised by the academic demands of their studies. This leads to “shock, anxiety and stress” among students in the early days of the programs, the authors of the report conclude.

Bilbie admits she contemplated quitting more than once during her first year, feeling she “didn’t have the knowledge, skill or judgment to do it.” During the toughest times, encouragement from a preceptor at her Toronto General Hospital placement helped boost her confidence. And during her first Christmas holiday in the program, when she was considering dropping out, she received a call from Ruth’s husband. He had looked her up in the phone book, and was checking in to see if she was still on the road to becoming an RN. This motivated her to get back on track.

Bilbie says the bridging program has deepened her nursing knowledge. As a hands-on learner, she appreciates its emphasis on community placements, as well as 600 practicum hours working under two different preceptors. As she has learned about her new role, she has also become part of her new professional association, joining RNAO and volunteering as an executive member of the Nursing Students of Ontario (NSO) interest group.

She will graduate from the program this summer, just a few months before her 40th birthday. She says she feels empowered by what she has learned, and is looking forward to having a greater impact on her patients and the health system as a whole. “I think the more education you have, the more people will respect you and listen to your voice,” she says.

But it wasn’t always easy.

Despite being shorter than the traditional four-year BScN degree, bridging programs present many challenges for prospective RNs. Going back to school full time was a major upheaval in Bilbie’s life as a mother of two adolescent children, and she sometimes struggled to balance her family and her studies while commuting two hours back and forth from London to George Brown’s Toronto campus.

Sue Coffey is an RN and associate professor of nursing at UOIT, former director of the university’s nursing program, and has led two major research projects evaluating bridging programs. She says

Hetal Patel came to a similar crossroads shortly after beginning his bridging studies at UOIT in 2014. Health care was a relatively new path for the mature student, who immigrated to Canada in 2008 from India, where he worked for a pharmaceutical company. He decided to become an RPN after injuring his hand, and spending a lot of time in the Canadian health system. He saw how respected health professionals were, and wanted to be a part of that.

As an RPN at Humber River Hospital, he pursued a lot of additional training – including certifications for IV insertion and wound care for complex patients – giving him a broader scope of practice than other RPNs. Some of his RN colleagues noticed his diverse skill set, and encouraged him to pursue his RN education. But studying full time, working full time, and spending so much time away from his wife and two children was a lot to handle. “In

my first semester, I felt like I should leave. It was so tough for me,” Patel recalls.

Buoyed by his supportive wife and “amazing” UOIT professors, he pushed past these doubts and completed his studies this spring. Once he passes his RN entry exam, he hopes to practise in an intensive care unit, and would also like to teach nursing down the road. “Being in the RN program (will) open more doors for me,” he says. “I feel more confident as a nurse that I can do multiple things.”

The desire for autonomy was a key motivator for Portia Machonisa as she went from RPN to RN, and then later studied to become an NP. She grew up in Zimbabwe, where she worked as a teacher, before moving to Hamilton in 2006 and deciding to go into nursing. Still adjusting to a new country and needing a steady income to support her son, she first pursued her RPN diploma. “It was a wonderful foundation for me,” she says. “It’s something I’m really grateful I did.”

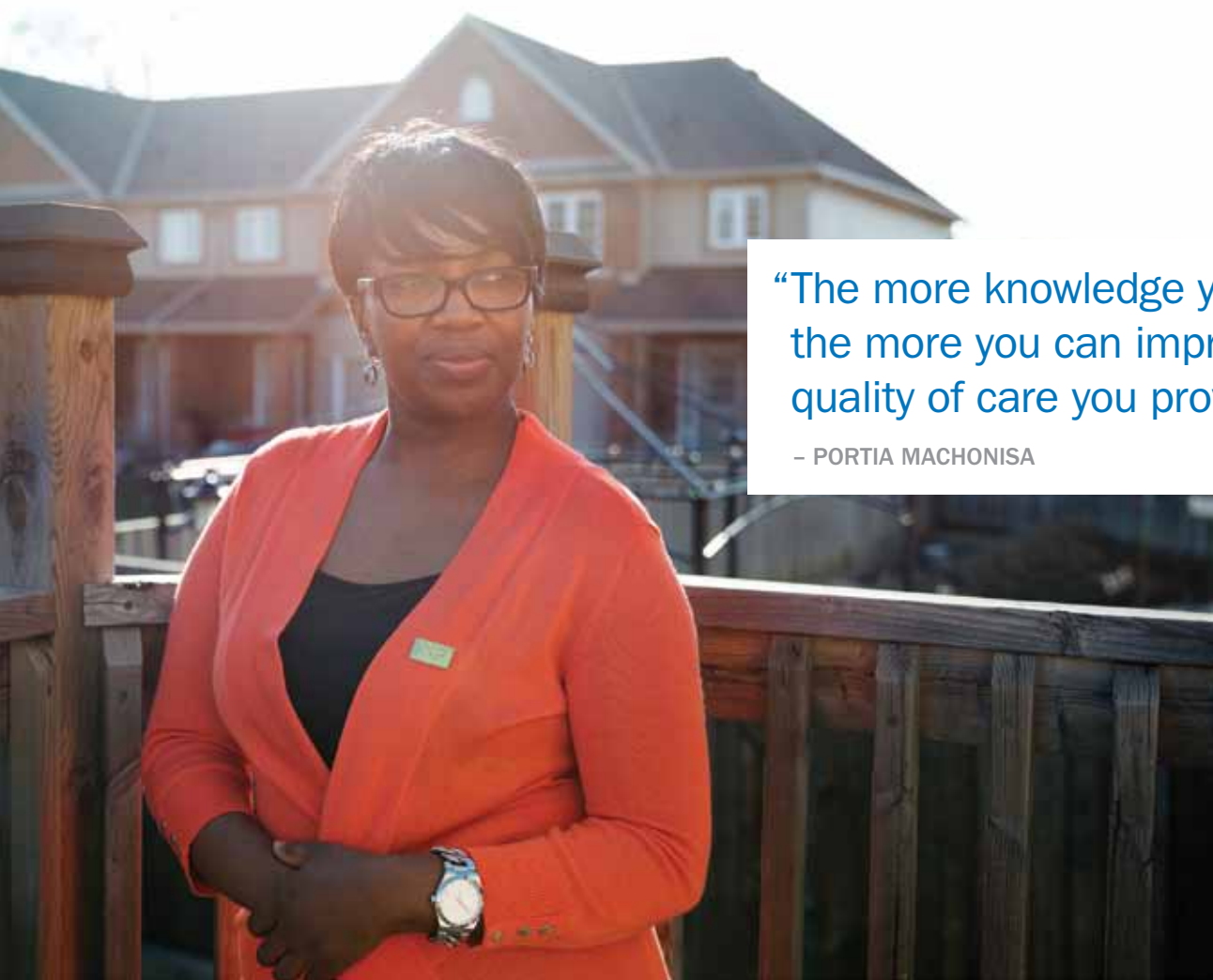
But Machonisa knew all along she wanted a broader scope. In 2009, the same year she finished her RPN diploma and got a job in the psychiatry unit at St. Joseph’s Healthcare Hamilton, she began the bridging program at McMaster University. She graduated and became an RN in 2011, but wasn’t done with her education. Four years later, she completed the master of science program at D’Youville College in Buffalo and has since become the attending NP at Fox Ridge Care Community in Brantford. “The more knowledge you have, the more you can improve the quality of care you provide, and be a role model for (your) colleagues,” she says.

Machonisa was motivated by a clear goal: she wanted to take on

a leadership role, and pursuing higher education was central to achieving that. Still, she admits it was difficult being a single mother juggling bills and tuition while studying and working full-time hours. “It’s important to know who you are, and what your goals are,” she advises. “This (transition) is something you have to really want for yourself.” Her rapid career progression was also challenging at times for her coworkers, especially while she worked as an RN on the same unit she previously worked as an RPN. “People know you as an RPN (and so) it’s difficult for them to come to you and take (the) directions you provide,” she says. “It took (them) a while to adjust and say ‘okay, she can be in charge, she can make decisions.’”

This resistance is not uncommon. The *Bridging the gap in RPN-to-RN transitions* review found new bridging graduates were not always immediately accepted in their new roles by their peers, and “initially struggled with their new professional identity because they felt undervalued and stigmatized by others.”

Coffey worries there is an unfair bias among health professionals toward bridging education and its graduates. She says much of it stems from a misconception that nurses become RPNs in the first place because their grades are not good enough to become an RN, and therefore they are not as qualified. “There’s an assumption that students on this (bridging) route are coming in through a ‘back door,’” Coffey says. But there are many reasons a nurse may have pursued an RPN diploma instead of a degree in the past, and that doesn’t make them an inferior candidate for their BScN today.



“The more knowledge you have,
the more you can improve the
quality of care you provide.”

– PORTIA MACHONISA

In fact, Coffey's research shows bridging students often score higher academically than their counterparts in traditional BScN programs, despite the challenges they face. Rather than being a back door, she says bridging programs promote equity and create "alternate paths of access to BScN nursing education."

To combat any stigma around bridging, UOIT combines students from both the bridging and traditional streams in some of its nursing classes in the later years of the program. Coffey says this benefits both groups: the traditional BScN students bring a refreshing idealism to class, while the "bridgers" bring valuable practice experience.

As an educator, Coffey says teaching bridging students is truly rewarding. "When you see how hard they're working to meet the requirements (of the program) and get everything they can out of their education, it's hard not to be inspired teaching them."

Hard work has been a hallmark of Bahar Karimi's career, no matter what role she was in. She got her start in health care as a PSW after an RN friend noticed the caring and compassion she brought to customer service, and insisted she make a career change. After completing her PSW course and getting work in 2004, she went immediately into the RPN program at Mohawk College in Hamilton.

She says her time as an RPN helped develop her passion for health care and build her soft nursing skills, but she yearned to have a greater impact. She enrolled in UOIT's bridging program in 2010 and calls it the best decision of her life. She says the program's professors and administrators recognize the unique needs of bridging students, and set them up to succeed. "(The education) was very personalized and individualized. We were not numbers, we were people to them," she says.



"The traditional BScN students bring a refreshing idealism to class, while the "bridgers" bring valuable practice experience."

– SUE COFFEY

"This knowledge has given me so much strength to feel I can do more... for my patients. It shaped me as a person – not just a professional."

– BAHAR KARIMI



That doesn't mean the experience was without challenges. Karimi was financially strapped during her studies, and needed to apply to every available scholarship and bursary. She worked combined full-time hours as an RPN at two Toronto hospitals, volunteered, and even gave birth to her first child during the program – but was back in class just two weeks later.

Still, her experiences in the bridging program inspired her to take her education even further. She graduated from UOIT in 2013, secured a job as an RN at North York General Hospital, and entered into a combined master of nursing and master of health sciences in health administration program at the University of Toronto (U of T) all within the same year.

She says gaining so much knowledge "has given me so much strength to feel I can do more...for my patients. It shaped me as a person – not just a professional."

Since completing her master's degree at U of T in 2015, Karimi has become director of resident services at Hamilton's St. Peter's Residence at Chedoke. She oversees a large interprofessional staff, and says having worked as a PSW, RPN and RN has made her a better leader.

"I can absolutely understand where (members of my staff) are coming from," she explains. "I (don't) need to put myself in the shoes of the PSWs, the RPNs, or the RNs, because I've been there. I've had those shoes on myself." **RN**


PHOTO: SUPPLIED

DANIEL PUNCH IS STAFF WRITER FOR RNAO.

TEACHING BRIDGING STUDENTS: AN EDUCATOR'S PERSPECTIVE

Bridging students bring unique skills and experience to the classroom. They also have unique needs educators should be aware of in order to help them succeed. Marianne Cochrane is a professor in the Durham College-UOIT collaborative nursing program, and has been teaching bridging students since 2012. She says there are a few things nursing professors should remember when working with bridging students:

- ▶ These are your colleagues, and need to be respected for the expertise they already bring to the table.
- ▶ Understand many are still working full-time, juggling work, family obligations and school responsibilities.
- ▶ Remember some bridging students travel hours to attend classes and take many courses in a single day.
- ▶ Be flexible when negotiating deadlines within reasonable timeframes.

A black and white photograph of Ontario Premier Kathleen Wynne standing and talking to two women seated at a table. She is wearing a dark blazer, a white top, a pearl necklace, and glasses. The women are also dressed in business attire. On the table are papers, a smartphone, and a glass of water. In the background, other people are seated at tables in a large room with framed pictures on the wall.

Ontario Premier Kathleen Wynne (centre) stopped by the breakfast portion of Queen's Park Day for some one-on-one conversations with members as they prepared to meet with their MPPs.

QUEEN'S PARK DAY

RNAO's political influence was evident at the association's 17th annual Queen's Park Day, where all parties supported key policy initiatives.

BY DANIEL PUNCH

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nseasonably warm late-February weather had many RNAO nursing leaders at Queen's Park Day (Feb. 23) thinking about spring. And after Health Minister Eric Hoskins [promised major progress](#) on several key nursing and health-care issues over the next few months, there seems to be more than just rising temperatures to look forward to. "It's going to be an important spring,"

Hoskins said to the more than 110 RNs, NPs and nursing students assembled for the association's annual signature political event.

Hoskins' big announcements – four in all – came during an afternoon Q&A session, which also featured Patrick Brown and Jeff Yurek, Progressive Conservative party leader and health critic, respectively, along with NDP party leader Andrea Horwath and deputy party leader Jagmeet Singh.

First, Hoskins told participants he would "very soon" bring forward legislative amendments to enable RNs to independently prescribe medications and communicate a diagnosis.

For years, RNAO has pressed government to expand RNs' scope of practice to include independent prescribing, and the association's advocacy efforts have since gained support from all three political parties. Hoskins himself promised to enable RN prescribing at past RNAO events, but he says tabling legislation is one of the final steps toward fulfilling that pledge. "This is something we've been working on for a long time. We really are at that last... important moment," he said.

These legislative amendments are just one piece of the puzzle when it comes to expanding scope of practice and increasing access to care. Hoskins also announced Ontario would soon be giving NPs the authority to prescribe controlled substances. As covered in the September/October 2016 issue of *Registered Nurse Journal*, Ontario is currently the only jurisdiction in Canada where NPs cannot prescribe medications under the *Controlled Drugs and Substances Act*. Hoskins said it was a "no-brainer" for Ontario to expand NPs' scope as well.

Horwath said her party continues to support expanding NPs' scope of practice, and will work with the government to ensure the initiative moves forward. "We need to make sure every nurse...can finally work to (their) full scope of practice," she said.

Moving on to another issue on RNAO's agenda, Hoskins said the government plans to fund offloading devices for Ontarians with diabetes. Because people with diabetes can lose sensation in their feet, they risk developing diabetic foot ulcers, which if untreated, can lead to life-altering amputations. Offloading devices relieve pressure on these ulcers so they don't progress to the point where amputations are needed. Presently, people with diabetes have to pay out of pocket for these devices. RNAO has urged the province to fund offloading devices in order to prevent suffering and save money from costly amputations – and the minister, crediting RNAO for moving this decision forward, committed to doing just that.



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1 Liberal MPP Granville Anderson had breakfast with members of RNAO's Durham Northumberland chapter, including Betsy Jackson (left), who is also Region 8 representative on the board of directors. The group discussed how expanded scope, including prescribing and diagnosing, will improve access to care.

2 Progressive Conservative MPP Ernie Hardeman (centre) and members of RNAO's Oxford chapter wrap up their breakfast conversation, which focused on safety and staffing in long-term care. (L to R) Brenda McCurdy, Leighanne Swance, Hardeman, Region 4 board representative Veronique Boscart, and Linda Holm.

3 Long-time NDP MPP and health critic France G  linas (right) sat down for breakfast with (from left) Allisa Ragnanan, Region 11 board representative Jennifer Flood, and former RNAO board member Paul Andr   Gauthier.

“We need to make sure every nurse can finally work to (their) full scope of practice.”

– NDP LEADER ANDREA HORWATH



4



Among the many things NDP leader Andrea Horwath addressed during her presentation were the challenges of precarious work, and the need for full-time employment for nurses.



5

4 Nursing Students of Ontario (NSO) immediate past-president Akuah Frempong stepped to the microphone following Christine Elliott's afternoon presentation, inquiring further about the former MPP's new role as patient ombudsman (see page 21 for more).

5 Students have always played an active and important role during Queen's Park Day, with a select few chosen to participate in placements at the event. This year's placement participants included (L to R) Kathleen Pikaart, Araniyaa Veratherajan, Allisa Ragnanan, Mili Patel, Amina Alizzi, and Alison Reavell-Roy.



RNAO President Carol Timmings (left) and CEO Doris Grinspun share a smile during the afternoon Q&A.

This was a big omission. We need to make sure nurses are added.”

– PROGRESSIVE CONSERVATIVE LEADER
PATRICK BROWN ON BILL 163, SUPPORTING
ONTARIO’S FIRST RESPONDERS ACT



According to Brown, increasing access to offloading devices has also been a priority for the Progressive Conservative party, because they “decrease wound care costs and help prevent amputations.”

Finally, Hoskins reiterated his desire to relocate Ontario’s more than 4,200 care co-ordinators to primary care. Currently, care co-ordinators work for the province’s 14 community care access centres (CCAC), which will soon be absorbed by the local health integration networks (LHIN). RNAO insists [care co-ordinators \(most of whom are RNs\) must be located in primary care](#) so they can co-ordinate care for patients with complex needs, and help Ontarians navigate the health system across the continuum of care.

The minister’s announcements are a clear indication RNAO’s evidence-based advocacy is influential in the halls of power. But the association’s growing political influence was evident right from the start of the day, when nursing leaders had breakfast with 52 MPPs from all three parties, and also greeted Ontario Premier Kathleen Wynne, who praised RNAO for its numerous contributions to help make Ontario stronger.

For Oxford chapter member Brenda McCurdy, and Region 4 board representative Veronique Boscart, this was the latest of many discussions with Oxford County progressive conservative MPP Ernie Hardeman. They maintain a good relationship with Hardeman and even met him in the lead-up to Queen’s Park Day to ensure both sides were prepared for their discussion. On the day of the event, they discussed various issues, including staffing levels and safety in long-term care homes.

RNAO’s impact was also on display later in the morning at question period, when Brown raised the issue of Ontario’s RN-to-population ratio – which RNAO has pointed out is the lowest in Canada – and when NDP health critic France Gélinas called for the minimum wage to be raised to \$15 per hour, something RNAO has been asking for.

During his speech at the afternoon Q&A, Brown lamented how nurses were left out of *Bill 163*, which provides easier access to post traumatic stress disorder (PTSD) treatment for first responders. “This was a big omission,” he said. “We need to make sure nurses are added.”

In addition to speaking about scope of practice, Horwath used her time at the podium to talk about her support for RNAO priorities such as developing a national pharmacare program and putting more emphasis on social determinants of health. “We stand up with nurses...and together with you...we stand up for patients,” she said.

Rounding out the day was a presentation from the province’s patient ombudsman Christine Elliott. The former MPP and veteran of many Queen’s Park Days explained the ins and outs of her new role – the first of its kind in Canada (see Q&A on page 21 for more from Christine Elliott).

Feb. 23 was an important day for RNAO, and it had many nurses reflecting on the evolution of the association and the nursing profession, says RNAO President Carol Timmings. “Increasingly, politicians from all parties are looking to RNAO for advice on developing healthy public policy,” she notes. “It’s a testament to how far RNAO’s influence has reached, how much we have advanced the nursing profession, and how much it is sure to continue growing in the future.” **RN**

DANIEL PUNCH IS STAFF WRITER FOR RNAO.



6 Progressive Conservative leader Patrick Brown talked to members during the afternoon Q&A about creating efficiencies in the health system, addressing nursing cuts, and supporting front-line staff.

7 Minister of Health Eric Hoskins (right) also paid a visit prior to his afternoon presentation, chatting with Quinte chapter president Chad Duff (left) and RNAO CEO Doris Grinspun.



Former MPP takes on task of investigating patient complaints

For the first time ever, Ontarians have their criticisms of the health system accounted for – and addressed – by the province's new patient ombudsman.

Christine Elliott was named [Ontario's patient ombudsman](#) in December 2015. The former Whitby-Oshawa MPP and Progressive Conservative health critic was selected for the role out of 400 candidates.

As patient ombudsman, Elliott is tasked with investigating complaints about hospitals, long-term care homes, and community care services, as well as making recommendations to health organizations and the ministry of health. Unlike other Ontario ombudsmen, she is not an independent officer of the legislature. Elliott is employed by Health Quality Ontario.

Her office began receiving and responding to complaints in July 2016 after months of consultations with stakeholders to define the mission and values of this new role – the first of its kind in Canada. RNAO participated in the consultation process, and Elliott continued her dialogue with nurses as guest speaker at the association's 2017 Queen's Park Day on February 23.

Registered Nurse Journal sat down with Elliott to discuss trail-blazing a new role, and what she hopes to accomplish during her five-year term.

Registered Nurse Journal (RNJ): Why did you want to take on this role?

Christine Elliott (CE): It's like a dream job for me, with my interest in health policy. I try to look at our health-care system in a holistic manner and make recommendations for systemic change to improve patient care and the patient experience. I want to be a trusted voice for patients in achieving fairness in health care.

RNJ: What kind of complaints have you received?

CE: We're hearing a lot about problems with communication. That is one reason why, although we've received more than 1,000 complaints so far, we've been able to resolve approximately 80 per cent at the early resolution stage. We are finding we can be an objective voice to mediate concerns between individual patients and health sector organizations.

The other issue at the individual patient level is a perceived lack of co-ordination and access to services, particularly in northern Ontario. On a systemic level, we're seeing concerns about transitions from hospital to home, and from hospital to long-term care.

RNJ: Do people appreciate having your office to address their complaints?

CE: Absolutely. We have received a lot of thanks from people (for whom) we've been able to resolve complaints. We're finding a lot of health sector organizations are also very happy because we can help them work with the complainants to find that resolution that has eluded them. Nobody wants to have somebody who feels they haven't found a resolution of their complaint.

Even when we don't have jurisdiction to help people (complaints against local health integration networks are under the ombudsman of Ontario's jurisdiction), we try to refer them to a place where they can register their complaints. A byproduct of the work we're doing is this navigation role of helping people know where to go with (their) issues.

RNJ: Your role is also to make recommendations to influence positive change in Ontario's health system. What kind of difference do you hope to make?

CE: We're always striving to resolve individual complaints, but often (they) are a symptom of something bigger – a systemic issue that's keeping health sector organizations from providing the care they want to provide. So I think it's important we all work together to bring those concerns to the attention of the people who can make a difference: the minister of health, the cabinet, and the premier.

I know my voice as patient ombudsman won't be the only voice advocating for change, but it will be uniquely from the patient's perspective. I think that's really important, and has not always been there. If we are trying to develop a truly patient-centred system of care, the patient's voice needs to be at the table.

RNJ: How do you think your experience as a former MPP and opposition health critic will help you in this role?

CE: My experience as an MPP is very similar to the work I'm doing now as patient ombudsman in that (I'm) receiving (public) complaints and working with health sector organizations to resolve them. I (also) learned a lot about the health system and how it operates as health critic...and I'm looking forward to working with trusted partners like RNAO to understand more about how the system works, and how it can be improved.

RNJ: Why did you accept the invitation to attend RNAO's Queen's Park Day to speak to nurses?

CE: I've always found my interactions with RNAO, particularly at Queen's Park Day (previously as an MPP), to be really informative. Nurses understand the patient experience and I can learn a lot from them. RNAO was integral to a lot of the things happening in health care now, including the *Patients First Act*.

I feel everyone comes into health care wanting to help people. Sometimes things may go off the rails despite everybody's best intentions, but it's important to work with frontline providers to find solutions...and I know that RNAO is constantly working on solutions. I think we have a great opportunity to work together to make sure patient and caregiver voices are heard, and acted upon.

RNJ: You talk about the "common good resolution" on your website. What does this mean in terms of the complaint process?

CE: When we did our consultations, we asked patients and caregivers what a resolution of their complaint would look like. What were they really looking for? While some indicated they were looking for an apology or an acknowledgment that something had gone wrong, over 80 per cent told us they would register a complaint (so) the same negative experience would not happen to anyone else.

I think everybody is coming into this with the right intentions, so I feel confident...we will be able to help to facilitate early resolutions of complaints, work together on some of the systemic issues, and provide concrete solutions that the government can implement. **RN**

DANIEL PUNCH IS STAFF WRITER FOR RNAO.



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ONE YEAR LATER

Syrian refugees (above, from left) Ibrahim Alkhalaf, 10, his sisters Dalya, 11, and Ansam, 14 (far right), their mother Amal (centre, right) and nurse practitioner and sponsor Lee-Anne Quinn (centre, left) enjoy some typically Canadian activities, including outdoor hockey and lacrosse.

We follow up with a Syrian family and the sponsors who brought them to Canada to find out how they're adjusting to their new home.

BY DANIEL PUNCH



Eighteen months ago, Amal Alkhalaf and her three children were afraid to leave their home. Now, their schedules are full.

Every morning, Amal wakes up early to get the kids ready for school before catching the bus to her 8:30 a.m.

English class at Fleming College in

Peterborough. She spends her afternoons with an English tutor, while the kids finish school and head to lacrosse camps, hockey games and air cadets meetings.

For the most part, the family has flourished since coming to Peterborough in December 2015 as refugees of the Syrian civil war. The kids are now fluent in English, and have taken up all sorts of typically Canadian activities. Amal is in school for the first time in her life, working to improve her English so she can find a job.

"It's quite impressive, but it's a lot of work for them," says Lee-Anne Quinn, a nurse practitioner and member of the 14-person sponsorship group that brought this family to Peterborough, and continues to support them.

The family's journey fleeing their war-torn Syrian hometown to Lebanon, and then being granted asylum in Canada, was featured in the January/February 2016 issue of [Registered Nurse Journal](#). They were also profiled in *Maclean's* magazine, and met Prime Minister Justin Trudeau when he visited Peterborough last January. It has been a whirlwind, and all things considered, Quinn says they're doing "fantastic."

But old habits, especially following traumatic events, are hard to overcome. Even though they now live in a fully furnished three-bedroom townhouse, the family often falls asleep together on the pull-out couch in their living room – just as they did on the floor of their Beirut apartment where they lived after escaping Syria.

More than 40,000 Syrian refugees have come to Canada under an ambitious resettlement program that began in November 2015. The project was celebrated by refugee advocates as a shift away from former Prime Minister Stephen Harper's less refugee-friendly policies. As a further sign of that shift, Prime Minister Justin Trudeau personally greeted one of the first planes full of Syrians arriving at Toronto's Pearson International Airport in December 2015.

But as the news cycle shifts away from the plight of Syrians, and the euphoria of being safe and away from a warzone subsides, refugees face a number of challenges to their health and well-being.

The one-year mark after landing in Canada is often when health issues that were put on the back burner by refugees can resurface, says NP Sue Grafe, who shared her expertise with colleagues during a series of RNAO webinars last year. Grafe works at Refuge: Hamilton Centre for Newcomer Health. For the first few weeks after refugees arrive, health practitioners at Refuge focus on ensuring immunizations are up to date, and helping newcomers familiarize themselves with the Canadian health system. During that time, Grafe says it's important they develop a therapeutic relationship with refugees so long-term health issues, including previously undiagnosed or untreated chronic diseases, can be addressed down the road.

Mental health is also a significant concern for settled refugees. The Centre for Addiction and Mental Health (CAMH) estimates between 10 and 40 per cent of Syrian refugees could face mental health issues now or in the future. Grafe says refugees are at an

"All I can do is be there to comfort her... and remind her she is in a safe place. She needs much deeper help than that, and that comes in her own language"

– LEE-ANNE QUINN

elevated risk for anxiety, depression and post traumatic stress disorder (PTSD). They also deal with intense grief from losing their homes and their loved ones, and worry for family and friends who remain back home. These issues, Grafe says, are not always treatable with medication or therapy.

Despite the stresses, NP Lynne Haslett of Toronto's East End Community Health Centre has been surprised by how well incoming Syrians have coped and acclimatized to life in Canada. When the Trudeau government announced its intention to bring tens of thousands of Syrian refugees to the country, Haslett anticipated she would be referring a large proportion of them to mental health services. But that hasn't been the case, and she says that's an important lesson for nurses. "We can't just assume (their past) is going to cause them horrible mental health issues," Haslett says. "We have to assess (refugees) using objective criteria, just as we do other populations."



“It’s quite **impressive**,
but it’s a **lot of work**
for them.”

– LEE-ANNE QUINN

has no intentions of ending its support for Amal’s family, but currently, her only regular income is from Ontario Works and the Canada Child Benefit.

Access to mental health services for refugees also changes after the first year, when counselling sessions are no longer subsidized under the Interim Federal Health Program (IFHP). Unfortunately, Haslett says the added pressure of financial insecurity after RAP runs out can be a trigger for mental health issues. That’s why nurses need to check in with refugees before and after the 12-month mark to see how they’re adjusting.

In Haslett’s experience, a refugee’s success in Canada is largely determined by their ability to learn English. But there are other factors that can make or break a refugee’s experience, and she says Canada needs more research into what these “success factors” are so they can be better supported.

Lee-Anne Quinn (centre) has developed a very close relationship with the Alkhalaf family since welcoming them to Canada in December 2015.

As an NP and their sponsor, Quinn was able to address many of Amal and her family’s immediate health needs, including looking after their immunizations and connecting them with a primary care provider and dentist. But she says they have hit a “stumbling block” when it comes to mental health. She is certain Amal is suffering from PTSD, but Peterborough does not have a counsellor who speaks Arabic, so they have sought out a counsellor in Toronto. That’s a 90-minute drive from Peterborough, and since Amal can’t regularly make the trip, her mental health needs are not being met the way Quinn would like. “All I can do is be there to comfort her...and remind her she is in a safe place. She needs much deeper help than that, and that comes in her own language,” Quinn says.

Amal is working hard at her English studies, and it’s important she does. It’s very difficult for her and other refugees to get a job in Canada without being proficient in the language. A senate report released in December 2016 found only half of all adult Syrian refugees in Canada have found work, and that language is one of their biggest obstacles to employment.

Finding work becomes all the more essential after the one-year mark, when refugees are cut off from monthly Resettlement Assistance Program (RAP) payments. Similarly, private sponsors are only obliged to support refugees financially for the first year. Without this support, refugees can find their housing, food and transportation in jeopardy. The Peterborough sponsorship group

Thanks to the generosity of the 14 Peterborough sponsors, and an incredible twist of fate, 10 more Syrian refugees may soon be on their way to Canada, including the husband Amal believed she had lost. She long assumed Usef, the father of her three children, had died after he went to the fruit market five years ago and never came back. It turns out, Quinn says, he was arrested at a protest without cause, thrown in jail, and prohibited from contacting anyone. After five years, he was released, and he set out to find his family. He heard many Syrian refugees were leaving to their new homes from Turkey, so he travelled there to look for them. He visited different consulates in Turkey hoping to find out where they ended up. In the Canadian consulate, he saw it: a photo of his family from the *Maclean’s* article. The consulate was quickly able to track them down, and in November 2016, Amal received a call she could never have expected. “They were just hysterical when they heard (his) name and heard his voice (on the phone),” Quinn says.

Soon afterward, the sponsorship group started the paperwork to bring Usef to Canada. They’re also sponsoring Amal’s brother, his wife, and their seven children. Quinn admits that taking more and more refugees away from their home countries isn’t the ideal solution, and she anticipates that one day, Amal and her family will want to return home. “The best scenario is to leave them where they are, but make the area safe,” she says. But because there’s no way to meet that goal, “This is a temporary solution in order to keep their mental sanity and physical safety.” **RN**

DANIEL PUNCH IS STAFF WRITER FOR RNAO.

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ACTION



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Nurses play a role in keeping our water clean by following the correct procedures to dispose of pharmaceutical waste. BY VICTORIA ALARCON

Registered nurse Kerrie Pickering knew something wasn't right when she saw an empty IV bag hanging over the side of a hospital sink on the acute medical floor she was working on seven years ago. The bag – which was full of the blood thinner heparin – had been cut and drained, allowing the medication to enter the hospital's plumbing system, the first step in its journey to our water supply.

"I was shocked," says Pickering, who, in addition to studying nursing, has her bachelor of science degree in environmental studies, her master's degree in geography, and is starting her PhD on the relationship between the environment and health. Her education, coupled with the findings of research she started in 2001, has taught her that although many pharmaceuticals are removed through the wastewater treatment process, some still make their way into Canada's drinking water.

After discovering the IV bag, Pickering went to investigate, asking several nursing colleagues what might have happened. A nurse confessed she had cut and emptied the bag down the drain. When Pickering asked her why, she said she didn't know what else to do with it.

"I think it's such a good example of the lack of education," said Pickering, noting that many nurses at that hospital were unaware of the correct protocol to dispose of pharmaceuticals.

If nurses are aware, they can make a huge impact, she says. "(Nurses) can (encourage) their employers to start disposing of pharmaceuticals appropriately if they're not. They can be vigilant in their work areas," she explains, adding that everyone in the hospital has a role to play.

According to the College of Nurses of Ontario (CNO), nurses must know how to implement [safe medication practices](#) including bio-hazard prevention when providing care to clients, self, other health workers, and the public.

However, Pickering says nursing students – including herself when she was a student in the early 1980s – do not learn about hospital waste management in their nursing curriculum. They also don't spend enough time on this during hospital placements.

"There is no time to devote to this," says Pickering, suggesting nursing schools and hospitals are already under so much pressure to fulfill their other responsibilities, and that the environment can be forgotten.

Edward Rubinstein, director of environmental compliance, energy and sustainability at Toronto's University Health Network (UHN), believes hospitals must prioritize the environment. "Hospitals are dealing with health, and one of the biggest impacts on our health is the outside environment," he says. "If we're polluting and wasting its resources, we're impacting our health."

At UHN, Rubinstein says the organization takes a proactive approach to education about the environment. Staff are notified about the different environmental policies through department meetings, group huddles, emails, posters, as well as one of their

most effective communication venues, their environmental blog [Talkin' Trash with UHN](#), which informs staff about how they have a role to play in making the hospital more green. "We really focus on communication and engagement," says Rubinstein.

Nurses in hospitals can make a huge difference in the work they do every day, Pickering says, beginning with disposing of pharmaceuticals properly, and according to their hospital's policy.

For health-care organizations such as UHN, drug disposal bins are available for nurses to drop off pharmaceutical waste such as partially filled syringes, pills, vials, and IV bags containing medications. Unopened IV bags and expired medications can often be returned to the in-patient pharmacy.

Nurses can also educate colleagues about the procedures. In 2010, Pickering created a green team at her workplace. A nurse on each floor volunteers to go around and remind staff about the

different disposal bins available for waste, and which ones to use. As a green team member, Pickering would also replace wrong bins with the right bins on drug carts, and let her colleagues know why she was replacing it. She says the key was to do this in a non-confrontational way by introducing herself and explaining the differences between the bins.

Pickering says she was considerate about the time of day she talked to colleagues, choosing the afternoon when most nurses at her hospital were available. "I would literally walk into the drug room with bins and posters...saying 'Hey, have you seen these posters before?'" says Pickering, adding that the nurses she spoke with appreciated learning about the different bins and which ones to use to dispose of pharmaceuticals properly.

Nurses can also make a difference outside hospital walls. As part of RNAO's Ontario Nurses for the Environment Interest Group

(ONEIG), Pickering has given online presentations to nursing students and included information in the interest group's newsletter about how pharmaceuticals enter the water supply, and how nurses can stop it.

When speaking with the public, she explains that health professionals of all types can inform them about how they should be disposing of their medications by bringing them back to their nearest pharmacy for proper disposal at no cost. The public will pay attention when health providers tell them that expired or unnecessary drugs should never be flushed down the toilet, she says.

"If we keep our environment healthy, it does better, and we do better," she says. "And it's doable in our everyday actions." **RN**

VICTORIA ALARCON IS EDITORIAL ASSISTANT FOR RNAO.

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What nursing means to me...

A PHOTO OF ALAN KURDI, HIS BODY WASHED UP ON SHORE IN AUGUST 2015, changed my perspective on the tragedy of the war in Syria. It was also the catalyst for my new-found appreciation that nursing is about learning from each and every interaction just how complex the human experience can be.

Alan and his family were attempting to cross the Mediterranean in an inflatable boat that capsized and left the three-year old, his brother, and his mother dead. Alan was not the first or last person to die trying to leave Syria, but his photo caught the attention of the world.

The first of 25,000 Syrian refugees began arriving in Ottawa around Christmas that same year. As a nurse practitioner, I was asked to treat refugees at a walk-in clinic on weekends in January 2016. Our first clinic was held in a hotel meeting room with one NP, a translator, and a bag of emergency supplies. We saw nine people. The next day, I arrived to find 30 refugees waiting, and no translator. Our makeshift clinic had a number of flaws, including a complete lack of privacy. We took over a suite that had a sitting room and separate bedroom. The bar fridge was full of juice and oral rehydration solution. We kept a chest of drawers full of condoms, thermometers, and bandages. NPs from two clinics provided walk-in care five days a week, with some working weekends. Around the city, other providers similarly offered care to refugees in hotels. Public health provided vaccinations and dental services.

The children – unable to play outside in the cold – amused themselves as kids do. To help alleviate their boredom, I collected art supplies. Ottawa's Somerset West Community Health Centre

started a play group two days a week. Even the local school board provided teachers to prepare the children for classes.

Allowed only one small bag per family in transit, the women did not have sanitary supplies. I began a crowd-funding campaign and, with the help of friends and family, packed kits of sanitary pads, Tylenol, chamomile tea, and brochures about women's health.

There have been some great highs over the past year. Hugs and smiles from people delighted to arrive in a new country. Babies born soon after arrival. There have also been some profound lows, including the challenges of childhood disability that may have been prevented with enhanced prenatal health care years prior.

By September 2016, a number of newcomers began showing signs of depression and anxiety. These symptoms have taken time to manifest. We've expected for some time to see cases of post traumatic stress disorder (PTSD) increase. This is balanced by the happy smiles of the children in my office, rushing to the book basket to show off their new English skills.

My experience helping Syrian refugees has meant drawing on everything I've learned since my first day in my undergraduate nursing program in the 1980s. I've addressed everything from basic needs like crayons and sanitary pads to complicated developmental disabilities. It was this range of the human experience that drew me to nursing, and the depth of knowledge that keeps me here. **RN**

LAURA KOLLENBERG IS A NURSE PRACTITIONER AT OTTAWA'S SOMERSET WEST COMMUNITY HEALTH CENTRE.



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