NOVEMBER/DECEMBER 2013

REGISTERED NURSE JOURNAL

Joining forces for FASD

RNs behind push to help colleagues better understand Fetal Alcohol Spectrum Disorder.

PM 40006768

Preventing back injuries • Solutions for poverty • 'Fellow' shadows RNAO CEO

VOL. 25, NO. 6, NOVEMBER/DECEMBER 2013

REGISTERED NURSE
JOURNAL

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Registered Nurses' Association of Ontario
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EDITOR'S NOTE KIMBERLEY KEARSEY

Poor choice or unavoidable misfortune?

A FEW MONTHS AGO, I LEANED over to tie my shoe and found myself struggling to straighten up. A 'twinge' is the best way to describe the initial sensation in my back when this simple movement went awry. It was followed by pain and limited mobility for longer than I would have liked. Fortunately, my back has healed, but the nurses we feature in this issue (page 18) haven't been as lucky.

If there's one common thread connecting RNs who have suffered back injuries on the job, it's their shared view that people who haven't experienced a back injury just don't appreciate how debilitating it can be. Bouncing back may just be a matter of playing the hand you're dealt, and managing the challenges that life throws your way. This is key for RNs trying to recapture some semblance of normalcy post-injury: accepting life is different and more limiting thanks to something that may have been preventable.

This notion of preventable suffering is one that comes through in our story about Fetal Alcohol Spectrum Disorder (page 12). Hundreds of thousands of people across Canada suffer from the disorder, often described as invisible and, in some cases, preventable with the right education. Nurses have an important role to play in raising awareness of the dangers of alcohol during pregnancy. And they are important advocates to push for more effective diagnosis, interventions and supports for those who are suffering. They must also understand they cannot blame mothers for the outcome of their pregnancies. And that's because "choice" may not come into play for some.

This notion applies to poverty as well. Nobody chooses a life of struggle. That message was loud and clear during a community led consultation in September (page 22). Individuals with lived experiences shared their suggestions on how to make life easier for those living in poverty. Here's hoping the provincial government has heard what they've said, and uses that insight to inform and shape its poverty strategy over the next five years. **RN**

PRESIDENT'S VIEW WITH RHONDA SEIDMAN-CARLSON

To immunize or not to immunize

AS YOU READ THIS, WE ARE IN THE midst of influenza season. Whether you work in a primary care clinic, long-term care, or a hospital, this is the time of year when flu symptoms can take their toll. And in some cases, especially for people who are frail or at risk, the flu can result in deadly consequences.

Each year there is ongoing debate among those who work in health care about whether or not to get the flu shot. It seems to me that no matter what information we receive, or what measures are put in place, not all of us are getting the message or see the need to be immunized. I know this comment may rile many of my nursing colleagues. Some will say: "Why is it only nurses who do not get immunized? What about the doctors?"

For me, the only legitimate reasons not to get immunized against the flu are if you are allergic to the components within the serum or if your immune system is compromised. Other than that, I have to ask nurses in Ontario: Why are so many of us not being immunized? According to the Canadian Healthcare Influenza Immunization Network, immunization rates for health-care professionals hover between 40 to 60 per cent. What's preventing us from having an 85 per cent immunization rate?

Why should we get the flu shot? It is interesting to hear some nurses say there is no need for them to be immunized because they never get sick. It is reassuring to hear how strong we are in combating disease, but are we looking to protect the wrong part of the nurse/patient relationship? In nursing, our credo is to work with patients and their families to assist them in coping with expected and unexpected life events. We are there to enable abilities, to help our patients maintain or attain health, and to ensure they are not exposed to undue risk. While we may be able to fight off influenza viruses, what about our frail patients? Shouldn't we do everything in our power to ensure they are not exposed to undue risk and to consider that, at times, we are the risk?

> "WHILE WE MAY BE ABLE TO FIGHT OFF INFLUENZA VIRUSES, WHAT ABOUT OUR FRAIL PATIENTS? SHOULDN'T WE DO EVERYTHING IN OUR POWER TO ENSURE THEY ARE NOT EXPOSED TO UNDUE RISK AND TO CONSIDER THAT, AT TIMES, WE ARE THE RISK?"

And, what about our own families? What about those of us with older parents and extended family? Don't we have an obligation to protect them from harm? If we house the influenza virus but do not become ill, can we say the same for our frail relatives? To be the vector of illness is not something any one of us wants to be part of when it comes to family and friends.

So what has nurses' reluctance to be immunized resulted in? Let me first draw our attention to the United Kingdom, where a number of parents had some of the same concerns around vaccinations against measles, mumps and rubella. The belief by some that children should acquire immunity naturally has resulted in significantly lower immunization rates over the last five to eight years. And now, what are we seeing? Endemic cases of mumps and measles with whole classrooms being affected as herd immunity no longer exists.

In India, polio is being seen in school-age children again at an alarming rate. One only has to look at photos of old polio wards in the late 1940s/early 1950s to appreciate the long-term effects that are possible.

When it comes to immunization, hospitals and other health-care facilities are trying to put mitigation strategies in place because they cannot force their staff to be immunized. Recently, there was a decision in British Columbia, which ruled in favour of hospitals that insist those who choose not to get immunized must wear a mask for their entire working shift. Here in Ontario, health-care organizations in Sudbury and London have put similar mechanisms in place. As in British Columbia, those who opt not to get the flu shot must wear a mask if there is an outbreak of influenza.

Nurses may decry the "stigmatization" of those who choose not to be immunized as "unfair." But I wonder if we, as a profession, are being fair to those who entrust us to keep them safe.

We should show the public how much we are there to do the best for our patients, families and communities by getting immunized.

I have received my flu shot. Have you? **RN**

RHONDA SEIDMAN-CARLSON, RN, MN, IS PRESIDENT OF RNAO.

For more information about influenza, and for links to Ministry of Health resources and campaigns related to the flu shot, visit www.RNAO.ca/flu2013

CEO DISPATCH WITH DORIS GRINSPUN

Expanding our grassroots power

TRADITIONALLY, WHEN THERE'S TALK of grassroots action at RNAO, it is automatically linked to political mobilization. And, indeed, RNAO has become a force to reckon with when it comes to empowering nurses in all roles and sectors – and nursing students – to become leaders in shaping the nursing, health-care and health-policy directions of our provincial government.

Just look at our success this year alone with regard to MPP participation in *Queen's Park on the Road* (QPOR) and *Take Your MPP to Work* (TYMTW), two events that would not be possible without the grassroots efforts of RNAO's chapters, interest groups, and especially our policy and political action executive network officers. Sixty-six MPPs participated in 68 TYMTW visits during Nursing Week, and 80 MPPs were visited in their ridings by 150 RNAO leaders for QPOR. This fall, we launched another QPOR initiative that is drawing even more MPPs to meet with RNs and nursing students in their local ridings. Of Ontario's 107 MPPs, only three chose not to engage with RNAO and its members in 2013. This intense political engagement – 97 per cent of all MPPs – means more power, more influence and more impact.

Our awesome success at RNAO is credited to the unwavering commitment and hard work of members at the grassroots level. The tsunami of influence that your dedication creates is astonishing, and has resulted in substantive policy improvements. Highlights include: higher than ever full-time employment; the new graduate guarantee; the late-career nurse initiative; NP-led clinics and NPs' expanded scope to admit, treat and discharge in in-patient hospital units; chief nurse executives and chief nursing officers as equal members of hospital boards and public-health units; and just last month, RNAO's success in securing a primary care nurse lead at the government level.

> "I URGE YOU TO JOIN THE TRIPLE ACTION GRASSROOTS MOVEMENT: POLITICAL ACTION, CLINICAL PRACTICE EXCELLENCE AND MEMBERSHIP GROWTH."

With our proven grassroots success in mind, let me issue a call to action in two additional spheres: clinical practice excellence and membership growth. Let's paint the picture together, and work together to make it a reality. Just imagine for a moment if we as a collective apply the same passion for grassroots political action to also build influence and inspire positive change in clinical practice. The ripple effect on patients, clients, residents, and communities across Ontario would be enormous. Imagine a grassroots movement of point-of-care nurses implementing evidence-based practice and building healthy work environments, joined by all nurse managers and all chief nurses. Such a phenomenal movement would transform the health system in a matter of months.

RNAO's Best Practice Spotlight Organizations (BPSO) are the trailblazers for this movement because these organizations have committed to using the association's clinical best practice guidelines (BPG) to transform the care they provide. The BPG champions' network leads this effort to shape clinical practice excellence. The network prepares individual nurses to champion BPGs in their own workplaces, giving them voice, tools and power to propel change. I invite every RN, NP and RPN – in all roles, specialties, sectors and communities – to join the network. With 92,879 RNs, 1,874 NPs, and 32,858 RPNs working in Ontario, the potential for a whole system transformation is huge.

Yes, we must think of point-of-care nurses in clinical practice as having the same grassroots power as RNAO members have mastered in political mobilization to influence policy decisions. Acting on this call to action will position nurse clinicians to have impact like never before.

My third and final call for grassroots action relates to membership growth in RNAO. We have come a long way from where we were 10 years ago. We have more than doubled our membership. Imagine just how much more we will grow if we parallel our stellar political action and clinical practice excellence grassroots movements with an equally robust membership retention and recruitment movement. We're already 36,000 strong at RNAO, and if every one of us shares with a colleague our active support for our professional association, we will double our influence and reach.

Yes, grassroots action to deliver membership growth is central to ensuring that RNAO – and nursing in Ontario – continue to move from strength to even higher strength, from influence to even higher influence, and from there to powerful impact that is good for Ontarians and for nurses.

I urge you to join the triple action grassroots movement: political action, clinical practice excellence and membership growth. **RN**

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

MAILBAG

RNAO WANTS TO HEAR YOUR COMMENTS AND OPINIONS ON WHAT YOU'VE READ OR WANT TO READ IN RNJ. WRITE TO US (250 WORDS MAX) AT LETTERS@RNAO.CA

Nurses must understand painful history to provide meaningful care for aboriginal populations

Re: The diabetes dilemma, Sept/Oct 2013

I thought I might share how, in reading the first part of your article about indigenous peoples in the Timmins area, I found myself thinking: 'Oh, I think *very* differently.' I do not agree that indigenous peoples 'give up very easily' as a general statement. Further, I do not think that referencing "emotional baggage" rather than "continued colonial harms" is sufficient as an explanation behind health disparities and difficulties engaging with western medicine.

Violent histories that include being forced to shift away from traditional practices, are not summed up well enough in "a shift in lifestyle changes."

The solution to keeping clients from walking out on you in the middle of a visit? Look to understanding these above issues as a means to build meaningful, trusting solidarity, instead of choosing patronizing solutions so as "not to overload them with details." You are painting a picture of a more helpless or perhaps less able group than what indigenous folk really are.

Without such an analysis, we are playing into continued colonial harms, of which western medicine has always been rather implicit.

Alicia Ridge
Hamilton, Ontario

Concealing diabetes only hurts those living with this chronic illness

Re: Diabetes: A discriminating disease, Sept/Oct 2013

I thought this article was very well written and addressed an important issue among people living with diabetes. As an individual with Type 1 diabetes who is also a registered nurse, I thought I would provide some further insight.

I have been fortunate to never have encountered discrimination from others in regards to having diabetes. In fact, in both my personal and professional lives, I have received immense understanding and support. I believe that this is highly influenced by my own positive perception of diabetes. I have always viewed living with diabetes as an accomplishment. I derive a great deal of my passion for life and nursing from the fact that I am able to successfully manage this chronic illness. It is my hope that by not concealing my diabetes, I am inspiring others with this condition to live healthful and fulfilling lives.

Caroline Pritchard
Toronto, Ontario

> "IT IS MY HOPE THAT BY NOT CONCEALING MY DIABETES, I AM INSPIRING OTHERS WITH THIS CONDITION TO LIVE HEALTHFUL AND FULFILLING LIVES."

RNs must "care" for clients and for colleagues

Re: President's View, Equal value must be placed on "soft" and "hard" knowledge and skills, Sept/Oct 2013

Nurses meet challenges every day. The expression "nurses eat their young" is all too common in our profession, and it should be buried in the past or changed to "nurses feed their young." I agree with the president's view that the softer skills of nursing (emotional, spiritual, caring aspects) are part-and-parcel of what nursing is. It is the essence of the profession and represents a key element of the important role nurses play on any health-care team. Although it is always easier said than done, it is important for all nurses – new and experienced – to recognize that we should not only care for and treat patients like family; we also need to care for our colleagues like family. It is the "caring" aspect of the nursing profession's reputation that nurses need to continue to uphold. We are here to care for others, and to also care for each other. We need to be able to work together and mentor each other towards the common goal of providing our patients with the best care possible as well as treating each other with care and respect. There are so many challenges that nurses face every day. I have seen and experienced challenges throughout my 20-year nursing career. It is high time nurses focused on honing the most important "soft" skill that's linked to what a nurse is all about. That is "caring" for others, and one another.

Ruby Crisostomo
Ottawa, Ontario

CLARIFICATION: The cover of our last issue notes "26 per cent of Canadians have diabetes." This number comes from the Canadian Diabetes Association, but includes Canadians with diabetes and pre-diabetes. We apologize for any misunderstanding.

NURSING IN THE NEWS

BY DANIEL PUNCH

Nurses want to scrub out *Scrubbing In*

Nurses across North America are speaking out against a new MTV reality TV show for what they call its sexualized, offensive portrayal of nurses. *Scrubbing In*, which debuted in October, features nine travel nurses living and practising in southern California. Scenes of the cast in the workplace are shown alongside scenes of drinking and partying after hours, prompting RNAO to write a letter urging producers to cancel the show.

Nursing students were among the first to express concern. **Alfred Lam**, a third-year Ryerson University student, says nurses already receive sexual comments in the workplace, and *Scrubbing In* could exacerbate the problem. The show's creators argue it will attract a new generation of nurses, "…but it wouldn't attract the right kind of youth," Lam says. (*Humber News*, Oct. 22)

University of Windsor nursing student **Alex Hopper** worries *Scrubbing In* may affect the public's trust in nursing. "(The cast) are people who are supposed to be actual nurses. They're not making us look all that great," the fourth-year student says. RNAO Windsor-Essex chapter president **Jennifer Johnston** believes the show is a step backward for nurses, suggesting it "…undermines the respect that we've worked so hard over the last century to develop." (*Windsor Star*, Oct. 22)

RN prescribing long overdue

It's time for Ontario to move forward with plans to allow RNs to write prescriptions, says RNAO CEO **Doris Grinspun**. During an appearance on the *Jerry Agar Show,* Grinspun explains how letting RNs prescribe basic medications can streamline the health-care system and improve patient outcomes.

The expanded scope "…will make the system much more efficient and effective and make the experience of Ontarians much better," she says. During an appearance at RNAO's 2013 annual general meeting in April, Premier Kathleen Wynne announced her intention to give RNs the authority to prescribe certain medications. Grinspun says the government has yet to act, noting that nurses in the U.K. have been prescribing medications for 15 years. "We are long overdue and it's time to move on if we want people to have same-day access." (*Newstalk 1010,* Oct. 15)

Student rescues crash victim

Emma Rockburn may have saved a life even before her graduation. The fourth-year Trent University nursing student was a passenger in a friend's car, travelling through a busy Peterborough intersection, when a vehicle in the oncoming lane swerved and struck another head on. Rockburn sprung into action, helping pull a man from one of the vehicles. "I got my friend to call 911 and I checked for his pulse and his breathing and he had nothing," she recalls. She performed chest compressions and was quickly joined by two other local nurses on scene. "We got a little team going," she says. "We managed to get a low, slow pulse started and we just kept going until help arrived." Weeks later, Rockburn learned the man was recovering well after surgery. She received a bouquet of flowers from his family, who told her that without her quick action, he likely would have died. "Nurses are heroes every day, and I was just lucky enough to help show that to everyone," she says. *(Peterborough Examiner,* Sept. 27*)*

Emma Rockburn

PHOTO: CLIFFORD SKARSTEDT JR/QMI AGENCY

Nurses help develop sexting education tool

Being a teenager is hard in the information age. To deal with the added challenges of an electronic world, the Chatham-Kent Public Health Unit has introduced new material on the dangers of sexting — sending sexual photographs via cell phone — to its sex education resources. "I'm glad (we) were able to play a part in that and pull it into this curriculum," says **Stacy Rybansky**, program manager of clinical services at the health unit. The teaching tool includes a short video about the legal dangers of sexting. The material was developed by the health unit in conjunction with **Sarah Daudlin**, a fourth-year nursing student at the University of Windsor, and designed for students in Grades 7 to 9. It has been implemented in 18 classrooms across the Lambton Kent District School Board since January. Even Rybansky, a self-proclaimed "social media person," admits she never imagined adding sexting to the curriculum. *(Chatham Daily News,* Oct. 17)

'It's about time' for NPs

A group of Sudbury NPs was featured in a *Sudbury Star* story about the 'It's About Time' campaign, a month-long initiative promoting NPs and their potential to ease stress on the overburdened health-care system.**Jennifer Clement**, **Marilyn Butcher**, **Roberta Heale**, **Kim Demers** and **Jennifer Dawson** practise at Sudbury District Nurse Practitioner Clinics. The original clinic opened in 2007 as Canada's first-ever NP-led clinic. "Feedback has been very positive," says Clement. RNAO teamed up with CNA and the Nurse Practitioners' Association of Ontario (NPAO) to promote the campaign, which features a series of print, radio and public transit ads urging the public to write their elected officials to demand more NPs. (Nov. 5)

More RNs needed to avert nursing home tragedies

Another violent incident at a nursing home shows increased staffing is needed to keep residents safe, says RNAO President **Rhonda Seidman-Carlson**. Speaking to the *Toronto Sun* and *Toronto Star* following the November death of an 87-year-old resident of Toronto's Castleview Wychwood Towers, Seidman-Carlson warns: "This is a situation that needs to be addressed and needs to be solved with the right staffing and right knowledge so that we're not dealing with this again." The deceased resident's 81-year-old roommate was charged with second-degree murder. In March of this year, a 72-year-old man was charged with the second-degree murder of a fellow senior at Scarborough's Wexford Residence nursing home. RNs are highly trained and capable of dealing with unpredictable patients, but most nursing homes are largely staffed with RPNs and PSWs, Seidman-Carlson says, adding it's up to the government to ensure resident safety through proper staffing. (Nov. 12)

Bringing breastfeeding to life with cardboard cutouts

Public health nurse **Melinda Bruno** hopes no one noticed the cardboard cutouts of

Cardboard cutouts of breastfeeding moms draw attention.

NURSING IN THE NEWS

OUT AND ABOUT

REMEMBRANCE DAY 2013

On Nov. 11, RNAO board member Claudette Holloway (Region 7) represented the association at a Remembrance Day ceremony at Toronto's Old City Hall. Holloway laid a wreath on behalf of nurses across the province.

RNs PREPARE FOR DEPLOYMENT AFTER TYPHOON

On Nov. 8, the Philippines found itself in the direct path of one of the deadliest typhoons ever recorded. In the aftermath of Typhoon Haiyan, RN volunteers with the Canadian Medical Assistance Teams (CMAT) prepare medical kits and relief supplies to be taken to the disaster zone, including inflatable field hospitals equipped with operating room capabilities. Given the severity of the disaster, and limited access to some of the hardest hit areas, volunteers, including Marty Quintia (right), know little about the specific health needs they will encounter once they are on the ground. They are preparing to focus on primary care needs such as skin infections, as well as the spread of infectious disease.

BOTTOM PHOTO: FRED LOEK/MISSISSAUGA NEWS

breastfeeding women scattered around Sault Ste. Marie this fall. The life-sized cutouts were placed in malls, arenas, and all around the region throughout October and November as part of an Algoma Public Health stigma-fighting initiative. While the campaign was a head-turner, the ultimate goal was to have no one bat an eye. "The point is to have people accept that this happens in public and be okay with it so that the moms who choose to do so feel a little bit more welcome," Bruno says. Each cutout featured a sign that read: "When you stop noticing, this will be accepted." Research shows breastfeeding is the healthiest option for mothers and their babies, and Bruno says mothers "…shouldn't be getting looks or be asked to leave places because they're feeding their child." *(Sault Star,* Oct. 3*)* **RN**

Letter to the editor

Kitchener RN **Jennifer Howell** *shares her view on literacy in this Oct. 4 letter-to-the-editor (excerpt), published in* The Waterloo Region Record.

The long and short of it: Let's spread the love of reading

There's a new four letter word I was exposed to recently. It is technically an acronym, but its meaning is repugnant enough that I feel it should suitably be categorized among other profanities.

The term I speak of is TLDR, which is Internet shorthand for "too long, didn't read," and all the cool kids are saying it, so to speak. TLDR is commonly found either in the online commentary under articles deemed too wordy to bother reading (the irony seemingly lost on the part of the commenter), or as a sort of header summarizing the contents of a piece for anyone who may find the full passage too daunting.

In a world where instant information comes in fun, bite-sized servings — all day long, from multiple sources, on a multitude of gadgets — the art of reading is dying.

According to the Ontario Literacy Coalition, our province has sustained a low literacy rate of 42 per cent for more than a decade, and an astonishing 40 per cent of our youth are lacking in reading skills as well. At a time when resources and information are much more accessible, I have no doubt we can do better, and there's no excuse not to.

It is my sincere hope that if we continue to invest in creative ways to celebrate literacy as a community, we can raise a generation of youth who find genuine enjoyment of reading, making the sentiment behind TLDR a thing of the past.

NURSING NOTES

Belleville RN is truly "remarkable"

Retired Belleville RN, respected municipal councillor (since 2006), and long-time RNAO member Pat Culhane wants to be clear about just how her nomination – and win – as that city's most "Remarkable Woman" in November has made her feel. "I want to tell you truthfully, honestly and unequivocally, I am humbled to have this award in the face of the competition," she said about the honour from local newspaper, *The Belleville Intelligencer*. This year's 12th annual competition was fierce (Culhane was one of 13 nominees). Her sister was behind the nomination, and says Culhane's "…life has been lived for others, completely." A survivor of spousal abuse and cancer, Culhane is an avid volunteer, donating her time to organizations such as the Canadian Mental Health Association, the Humane Society and the Multiple Sclerosis Society.

PHOTO: EMILY MOUNTNEY/BELLEVILLE INTELLIGENCER

RNs to begin dispensing medications in January 2014

Four years ago, the provincial government passed a series of amendments to legislation that governs regulated health professionals, and in doing so, opened the door to expanding the scope of practice for RNs and RPNs to include dispensing medications. Recent changes to the *Nursing Act, 1991* mark the final step towards this expanded scope, which comes into effect in January 2014. In the past, nurses could only dispense drugs through delegation. Beginning next year, new regulations authorize RNs to dispense when an order is provided by an authorized practitioner such as a physician or NP. The College of Nurses of Ontario's (CNO) *Medication* practice standard will be updated to reflect expectations for practice, and to provide nurses with the guidance needed to dispense a drug safely. CNO says its revised practice standard will be available online (www.CNO.org) Jan. 1, 2014. RNAO spent months in 2009 advocating for these changes to legislation and regulations that oversee the practice of nurses, but expressed disappointment the amendments didn't go far enough at the time to reduce wait times and improve access.

Canadians open to conversations about end-of-life care

Saint Elizabeth, a national, non-profit health-care provider, is challenging conventional wisdom with the October release of a survey that reveals more than 80 per cent of Canadians are comfortable talking about end-of-life care issues. "This level of readiness will help us have these important conversations with individuals and their families," says Shirlee Sharkey, the organization's president and CEO. Conducted by Environics Research, the web-based survey found half of respondents would prefer to receive end-of-life care at home, but most believe it's offered only in nursing homes, hospitals, hospices and retirement homes. Only one in 10 saw their home as an option. Although most people want to die at home, there is "tremendous anxiety about how a home death might burden their families," Sharkey says, "and how their medical treatment would be administered, and even who would pay for it." Twenty-five per cent of respondents over the age of 30 have made end-of-life plans. Those over 70 are only slightly more prepared, with 40 per cent saying they've done some advance planning.

Three RNs and advocates for vulnerable populations receive awards

This fall, three nurses who have focused their careers on vulnerable people (who live on the street and/or who have mental health challenges) were honoured with awards from three different organizations. Kitchener's Tracey Collins, Toronto's Cathy Crowe, and London's Cheryl Forchuk each received recognition for the important work they do and the influence they have had on policies affecting the vulnerable. Collins received a *Kitchener-Waterloo Oktoberfest Rogers Women of the Year Award* for her work with the city's homeless through The Working Centre's psychiatric outreach project. Collins has pioneered a nursing role in non-traditional settings such as community kitchens, in shelters, the courts, parks and drop-in centres. Crowe, an educator, author and film producer who has been a vocal and visible advocate for Toronto's homeless for many years, was appointed as a distinguished visiting practitioner at Ryerson University, and will help to develop a one- to two-week training course for youth called the *Jack Layton Summer School for Youth Activism*. Forchuk received a *Recovery Research Award* from Psychosocial Rehabilitation Canada for a project she headed that put cell phones in the hands of 400 people struggling with schizophrenia and depression. The devices helped them to track their own triggers and stay out of hospital. **RN**

Do you have nursing news to share? Email editor@RNAO.ca

A TROUBLED LIFE

Thousands of children suffer from Fetal Alcohol Spectrum Disorder. Nurses can help by advocating for greater awareness of the risks of drinking during pregnancy, and by supporting more effective diagnosis, interventions and supports for those with the disorder. **BY MELISSA DI COSTANZO**

Six years ago, and well into her second summer working as a nurse at a camp for children with special needs, including attention deficit hyperactivity disorder (ADHD), Kathy Moreland Layte began to detect a puzzling trend. The Kitchener NP noticed some kids struggled when responding to everyday occurrences. Mark* lashed out, verbally and physically, after a friend accidentally bumped into him. Jake,* who was fond of his camp experience, became aggressive a handful of times, even though he was told he would be sent home if he didn't calm down. He continued to act out, and was eventually told to leave. Medication and counselor supervision didn't curb their outbursts, and Layte thought: "this doesn't fit with what I know about ADHD. These kids should have been able to manage…because other children with ADHD do. There's something else going on."

Layte, a seasoned RN with 22 years in oncology and palliative care experience under her belt, mentioned her musings to the psychiatrist she worked alongside, and was taken aback by his response. Many children – including potentially some of the kids at the camp – have undiagnosed Fetal Alcohol Spectrum Disorder (FASD), he said. An umbrella term that encompasses an assortment of effects, FASD can cause physical, psychological, behavioural, and learning limitations with lifelong implications in those whose mothers drank alcohol during pregnancy.

Many kids with FASD are first diagnosed with ADHD thanks to similar indicators. Symptoms of FASD are a result of the permanent brain damage caused by use of alcohol in pregnancy. They include language processing impairments, vision and hearing difficulties, growth deficiencies, and heart, kidney, liver and other organ damage. These can lead to poor memory, trouble with judgment, and lack of impulse control.

Layte admits now that the only knowledge she had of the disorder at the time could be traced back to her undergraduate studies, when she learned during a psychology lecture that there are facial features that sometimes go hand-in-hand with an FASD diagnosis. Many presume all children diagnosed with the disorder bear the telltale physical signs, including a thin upper lip, a short nose, and an indistinguishable philtrum (the groove between the nose and upper lip). This is simply not true, Layte explains. Those who show no (or less) physical signs also suffer.

"I'm ashamed of myself for how ignorant I was," says Layte, a full-time professor of nursing in the McMaster University/Conestoga College/Mohawk College collaborative BScN program.

She began to do some digging on the disorder and unearthed some alarming statistics. One per cent of Canadians (or approximately 350,000) are estimated to be living with FASD, though many peg that number as much higher given the reluctance of some mothers to share details about the amount of alcohol they consume while pregnant. FASD is also difficult to diagnose.

There are approximately 130,000 Ontarians living with FASD, and one of them is Jacob,* the adopted son of a woman Layte befriended after her three summers as a camp nurse. Jacob was repeatedly removed from school because he would become aggressive, and his mother quit her job to look after him. "It affected her livelihood completely," Layte says, adding the pain she felt for this child and his mother was too great to ignore. Thoughts raced through her mind: what happens to these kids when they grow up? What kinds of supports are available for families? Why don't nurses know more about this disability? "I felt I had to do something," she says. "No parents or caregiver should have to go through this kind of agony. There needs to be more awareness and action."

Layte now considers herself something of a crusader, having committed to helping health-care providers – RNs included – become more aware of the disorder, best practices regarding prevention, and the effects on those living with the condition, their families, caregivers and the health-care system.

FASD IS A COMPLEX DISABILITY THAT OFTEN ISN'T EASILY PINPOINTED. THE CANADIAN DIAGNOSTIC GUIDELINES WERE ONLY COMPLETED IN 2005.

And she's not alone.

Nurses working in the community, public health and policy development are also drawing attention to this pervasive health concern, although they agree many more health professionals still need to better understand FASD. Those who work directly with FASD clients daily agree the disorder has received more attention over the years, yet all say there is still a lot more work that needs to be done – starting with prevention by outlining the dangers of alcohol to women, and reforming and beefing up the diagnostic process.

FASD is a complex disability that often isn't easily pinpointed. Canadian diagnostic guidelines were only completed in 2005. New guidelines are expected to be released in March 2014. Currently, a confirmed prenatal birth history that the mother used alcohol is necessary for diagnosis. This information is not always available, which means many may never know if they're living with the disorder. Often, nurses are one of the first points of contact with the health system, and play a critical role in helping to gather this crucial piece of the puzzle by asking patients if they are in touch with their biological mother, or if they are aware of a history of alcohol use.

Province-wide, 14 diagnostic clinics exist: six in Toronto, two in Durham region and one each in London, Kingston, Peel region, Waterloo region, Sudbury and Thunder Bay. Tannice Fletcher-Stackhouse works as a primary care NP at Thunder Bay's NorWest Community Health Centre. She sees clients of all ages in the FASD program alongside another NP and a physician. It's the only such clinic in the area, and it's come a long way since its inception 11 years ago.

In 2002, Thunder Bay patients were referred to Toronto's St. Michael's Hospital for diagnosis. Five years later, the team in Thunder Bay began hosting videoconferencing consultations. Now, the program boasts pre- and post-diagnostic support services for both clients and their families. Neuropsychological exams are done ahead of time to help streamline the process. The two NPs do physical exams and take facial measurements. If a client has complicated medical needs, they see the physician.

There is a high no-show rate, likely because FASD can affect memory. Stackhouse says case managers are attached to all clients. They act as navigators by providing support, helping to secure housing, and ensuring appointments and transportation are arranged. Staff also follow up by calling, initiating home-care visits or handing out bus tickets to help patients travel to their appointments.

Thunder Bay NP Tannice Fletcher-Stackhouse (right) hosts a community kitchen twice a month to give clients the chance to socialize.

Another service the centre offers is a community kitchen for clients to learn how to cook. "People with FASD are very hands-on learners. This (kitchen) is…about socialization with other people, learning cooking skills, and safety," says Stackhouse. The centre's staff also organize outings such as fishing and camping trips, opportunities their clients may not otherwise have access to because "they lack a lot of social skills, they're often shunned or taken advantage of," Stackhouse says.

She's quick to clear the air when it comes to perceptions surrounding FASD prevalence in certain populations, such as the Aboriginal population, or those from lower socio-economic backgrounds. "We're seeing more people…whose mothers were upper-middle class, well-educated," says Stackhouse.

This isn't the only misconception that exists about FASD. Layte says she often surveys her students, asking them to tell her: between alcohol, cocaine and heroin, which would be least toxic to a fetus? The response is usually alcohol. In fact, all three can cause damage and, in some cases, the damage by alcohol is the worst. Alcohol is not filtered by the placenta, she explains, and ethanol is toxic to neural tissue, resulting in permanent brain damage. An emphasis on FASD, and how alcohol affects a developing baby, should be required in all nursing school curriculums, Layte suggests.

Mary Mueller agrees. Mueller is an RN with the Region of Waterloo Public Health's *Reproductive Health and Healthy Family Dynamics Program*, where she supports the health and wellbeing of pregnant women, new mothers and babies who face a range of challenges.

Fuelled by her patients' anecdotes and some alarming statistics, Mueller joined the FASD Ontario Network of Expertise (ONE) prevention working group. Layte, who works with another member on that group, mentioned she wanted to encourage RNAO to address FASD. Mueller had a similar goal, and the two RNAO members were connected by a colleague.

The pair drafted a resolution that was unanimously passed at RNAO's 2012 annual general meeting. It calls on the association to advocate for an integrated strategy in Ontario to address FASD that includes: prevention, best practice screening guidelines for addictions, accessible and better diagnosis, evidence-based interventions, and appropriate support services for individuals and families.

The resolution was a step Sharron Richards calls vital. "(RNAO) is a huge group of health providers…who think this is a significant enough issue," says the chair of FASD ONE. "(It's) a very strong statement (from) the health system." Now it's "really time for our provincial government to step up," she adds.

Ontario does not have a provincial framework to address FASD. British Columbia, Saskatchewan and Alberta are among those that have set out roadmaps – often with dedicated funding – to help tackle the issue. FASD ONE is in the midst of developing a strategy it's planning to present to the government early next year. The group's hope is that the document will be adopted, either entirely or in part.

PREVIOUS PAGE PHOTO: ISTOCK

PHOTO: SANDI KRASOWSKI

FASD FACTS

There are approximately **130,000** Ontarians living with FASD.

Ontario is the **only province in Canada** without a government-led FASD strategy.

Canada's *Low-Risk Alcohol Drinking Guidelines* suggest there is NO safe amount and NO safe time to drink alcohol during pregnancy.

The first published literature linking prenatal alcohol use to birth defects was in France in **1968**.

It's estimated there could be as many as **7,600** children in Canada's child welfare system (protective services) who have FASD.

The average daily cost for a child in care who has the disorder is approximately **20 per cent** higher than that of other children in care who do not.

Annual cost of care includes everyday expenses such as food, child care, and utilities, as well as special needs funds for therapy, medical expenses, and fees for service. It also includes funding for exceptional circumstances, including support services, criminal legal fees, and renovations to a foster home.*

Caring for FASD clients costs Canadians as much as **$7.6 billion** every year.

* *Pseudonyms have been used to protect privacy.*

*Source: *Canadian Children and Youth in Care: The Cost of Fetal Alcohol Spectrum Disorder*, published in *Child and Youth Care Forum Journal of Research and Practice in Children's Services*, August 2013

To help fill the gaps in the meantime, Mueller and Layte are helping to organize a webinar (see sidebar). They have also joined forces with six other nurses – including Stackhouse – on a working group that grew out of RNAO's resolution. They meet to discuss: how they can partner with other groups to advocate for FASD; how they can increase awareness and skills in nurses; what types of provincial policies are needed to prevent FASD; and how to better support those with the disorder.

At work, Mueller strives to create a supportive environment for her clients to talk about their substance use. Suspending judgment and listening helps them to open up, she says. "Prevention is key, but we also need to think about decreasing the damage done by alcohol exposure in pregnancy. We will not prevent all the damage from alcohol exposed pregnancies, but we can lessen the impact," says Mueller. "You can't say it's 100 per cent preventable because of the nature of our society. We do have violence, we do have unplanned pregnancies, we do have people who are feeling unsupported and (living with) mental health issues, so they're using alcohol for different reasons."

The Public Health Agency of Canada estimates the rate of unplanned pregnancies to be approximately 40 per cent. This is why RNs should focus on prevention by screening all women in their childbearing years, Mueller charges, and by asking questions such as: how many drinks does it take to make you feel drunk? Have you ever thought about cutting down on your drinking? Have people annoyed you by criticizing your drinking?

If this is only one routine aspect of health assessments, clients are less likely to feel singled out, she adds. "If they say 'I don't drink at all,' I say 'that's great. Alcohol can cause brain damage in pregnancy, so I'm really happy to hear you're not drinking.'" Sharing this information may prompt women to come back and disclose at another time, and "...sometimes, they do." Nurses can also keep partners and spouses in the loop by encouraging them to be supportive, and assuring them there are places to seek assistance.

"With the high rate of unplanned pregnancies, waiting to talk about alcohol until a woman is pregnant is simply too late," says Mueller. "If you begin risky drinking at a younger age, you're more likely to drink at higher levels as you get older and therefore more at risk for having an alcohol-exposed pregnancy,"she says. And, if numbers are any indication, she may be right.

Statistics Canada's 2013 Canadian Community Health Survey indicates 30 per cent more women engage in risky drinking than 10 years ago. Risky drinking constitutes five or more drinks in one sitting, once or more a month. As well, the Canadian Centre on Substance Abuse released a report in November 2013 that found 11 per cent of pregnant women consume alcohol. The document uses data from the *2008 Canadian Perinatal Health Report*, the fifth national surveillance report from the Canadian Perinatal Surveillance System.

Canada's *Low-Risk Alcohol Drinking Guidelines* suggest no more than 10 drinks a week for women (with no more than two drinks a day most days) in order to reduce long-term health risks. If you are pregnant or planning to become pregnant, think you might be pregnant, or about to breastfeed, the safest choice is to drink no alcohol at all, the guidelines say. Communicating this information through strategies, recommendations and policies aimed at mitigating alcohol use is vital when it comes to raising awareness around FASD, Mueller says. "We need to think about (the disorder) in a broad fashion...and build (it) into (all) alcohol (related) policy," she says.

That's one aspect of Carol Perkins' job. She's a public health RN in the Region of Waterloo Public Health's *Injury and Substance Misuse Prevention Program*. She says a holistic approach and strong relationship-building skills are valuable assets when it comes to substance abuse prevention. Her role spans from policy advocacy to educating youth about alcohol consumption.

STATISTICS CANADA'S 2013 CANADIAN COMMUNITY HEALTH SURVEY INDICATES 30 PER CENT MORE WOMEN ENGAGE IN RISKY DRINKING THAN 10 YEARS AGO.

Nine years ago, Perkins started working with the cities of Cambridge, Kitchener and Waterloo, and the townships of Woolwich, Wellesley, Wilmot and North Dumfries to develop individual municipal alcohol policies, a mandate handed down from the province to all 36 health units in 1997. Waterloo region now has a draft municipal alcohol policy that aims to reduce alcohol-related issues such as injury, violence and liability, which arise from alcohol consumption on municipal property.

Provincially, changes to laws linked to substance misuse have helped to keep the dangers of alcohol consumption on the public radar. These include: graduated licensing (there is zero alcohol allowed for all people 22 and under who are fully licensed drivers), and *Sandy's Law*, a private member's bill introduced 10 years ago by former MPP Ernie Parsons (Prince Edward-Hastings County) whose late son, Sandy, had FASD. It requires certain premises to prominently post signs warning women that drinking alcohol during pregnancy can cause FASD. The blood-alcohol concentration for drivers has also been lowered from 0.08 to 0.05 per cent.

Kathy Moreland Layte (left) and Mary Mueller are on a mission to raise awareness of FASD through their RNAO resolution.

PHOTO: DANIEL EHRENWORTH

Perkins and many other public health nurses actively advocated for many of these changes as part of their roles. That advocacy work continues, she says. And, at the top of her priority list is maintaining the LCBO's status as a government monopoly when it comes to the sale of alcohol. Selling alcohol in facilities other than a government monopoly "increases availability, and anytime there's increased availability, there's the likelihood of increased drinking and increased harm," Perkins says. "From a FASD perspective for prevention, keeping the LCBO as a government monopoly is really important to limit access."

Perkins admits her job isn't without its challenges. Timing and community readiness are key factors that help to ensure policy is passed into law. Funding also poses problems. She presses on by finding champions or community partners who will convey her messages. She writes letters or briefing notes to the medical officer of health who will take them to regional council meetings, to keep councillors informed. "Nurses aren't necessarily seen in policy development as leaders, but we certainly can be," she says. "We really are collaborative catalysts for change."

This is exactly why Layte will continue to fight for greater FASD awareness. Every youngster living with the disability deserves to have the same rights and privileges as any other child, she says, including proper supports at school and access to recreational activities. "My new passion has become this issue because...the families and children who might not know how to be politically active (deserve it)," she says. She hopes all nurses will consider that within every context of practice, one out of every 100 people is living with FASD, often undiagnosed. This has huge implications for patient teaching, treatment compliance and secondary mental health issues such as chronic anxiety, depression and substance abuse.

Together, Layte and Mueller aim to educate nursing colleagues to help prevent women from drinking while pregnant. The duo will also carry on with their plans to draw attention to the gaps that exist in identification, diagnostic, individual and family services for those living with what Layte calls "this often invisible disability."'With resources becoming more and more stretched, the prevention of FASD and the needs of those with FASD must be championed," she says. "Nurses...are in the position to do just that because of our commitment to, and awareness of, the determinants of health, and our strong political voice." **RN**

MELISSA DI COSTANZO IS STAFF WRITER AT RNAO.

Webinar sheds light on substance use during pregnancy

Pregnancy and Substance-Involved Clients is one of four sessions in a webinar series offered by RNAO, the Centre for Addiction and Mental Health's *Opioid Awareness Treatment and Education Program*, and the International Nurses Society on Addictions. It takes place on Dec. 11, 2013, from 11:00 a.m. to noon.

Participants will be able to: identify the prevalence of substance use in pregnancy and for women in their childbearing years; list the effects that opiates and alcohol consumption have on a developing baby; identify effective strategies to help pregnant women abstain from or reduce substance use in pregnancy; and identify the role of the nurse in prevention and treatment of substance use in pregnancy.

To register for the Dec. 11 session, visit http://www.intnsa.org/events

The final two sessions in the series will focus on *First Nations/Aboriginal Youth and Opioids* (Jan. 15) and *Mental Health, Addictions and Practice Standards* (Feb. 5).

Visit www.RNAO.ca/opiate-webseries, or contact Glynis Gittens, gvales@RNAO.ca, for more information.

Spending $150,000 to prevent FASD could save **$1.6 million** in treatment nationally.

Each child with FASD in foster care in Canada will cost the system **$2,000 annually**.

The umbrella term FASD can include:

FETAL ALCOHOL SYNDROME (FAS): People prenatally exposed to alcohol who are living with growth deficiency, height or weight below the 10th percentile, physical characteristics (a smooth philtrum and/or thin upper lip), and/or central nervous system damage.

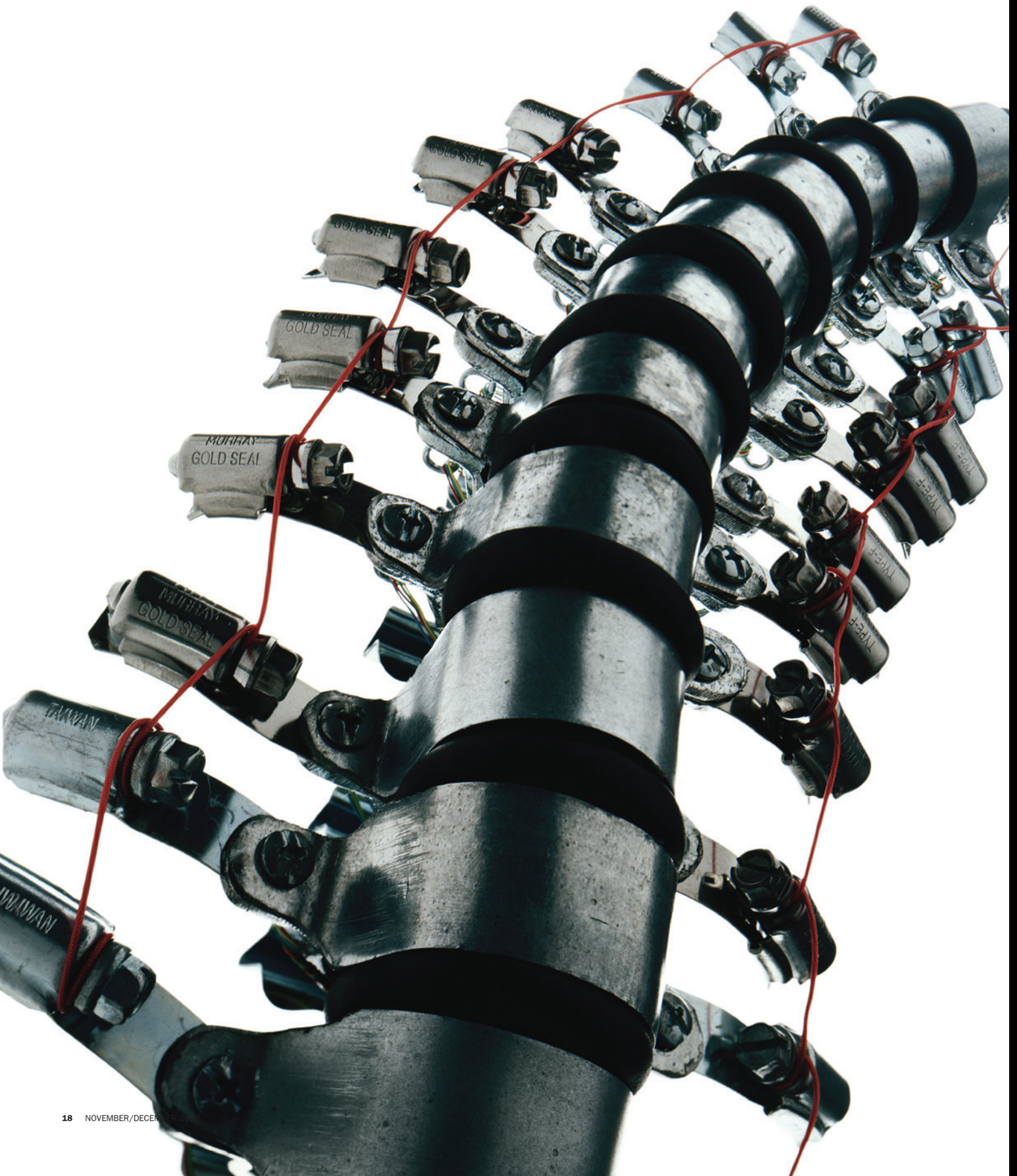
PARTIAL FETAL ALCOHOL SPECTRUM DISORDER (pFAS): People who were prenatally exposed to alcohol and who are living with some (but not all) of the physical symptoms of full FAS.

ALCOHOL-RELATED BIRTH DEFECTS (ARBD): People who were prenatally exposed to alcohol and who have defects such as malformations of the heart, bone, kidney, vision or hearing systems.

ALCOHOL-RELATED NEURODEVELOPMENTAL DISORDER (ARND): People who were prenatally exposed to alcohol and who have symptoms of central nervous system damage.

Sources: Canada FASD Research Network, Public Health Agency of Canada, Institute of Health Economics, Canadian Federation of University Women, Canadian Centre on Substance Abuse, Canada FASD Research Network, Region of Waterloo Public Health, Child and Youth Care Forum Journal of Research and Practice in Children's Services, Alberta.ca, National Collaborating Centre for Aboriginal Health

THE BODY MECHANIC



Although research points to a need for better policies to protect nurses from back injury, the onus is often on RNs to watch their everyday movements and motions that may lead to long-term pain.

BY KIMBERLEY KEARSEY

Janet Klok's experience with back injury is probably more extreme than most RNs will ever face, but it's an indication that anything can happen if you move the wrong way at work. She's experienced everything from bullying, to fights with the Workplace Safety and Insurance Board (WSIB), to two lay-off notices, and arbitration through her union. Her story may not reflect the norm, but it's one that certainly illustrates just how much your life can change when you twist awkwardly to help a patient.

It was a Sunday at 4 a.m. There were only three nurses working on the neurosurgical floor where Klok was filling in as a member of the float team. Having worked on the unit many times, she knew some of the patients, including Gloria,* who had just had surgery the Friday before. Gloria was up and about, fully cognizant, and seemingly in great spirits when she and Klok crossed paths earlier that night.

As the veteran RN (she had 20 years of on-the-job experience) finished up her rounds in the early hours of that morning, she heard an unusual sound down the hall, and worried it was the man who had already pulled his tracheotomy tube out several times that evening. As it turned out, he was sleeping soundly. Klok continued to search for the source of the sound, and arrived at Gloria's room to see her climbing out of bed. She went in to help, standing at the foot of Gloria's bed as the groggy woman grasped her walker and headed for the bathroom.

Out of the corner of her eye, Klok noticed Gloria lowering herself at the side of the bed, convinced she could squat right there to relieve herself. Klok grabbed her confused patient by the arm and began to pull her back up, fearing she may scrape or open her fresh incision. "I've turned a 500-pound patient by myself, so I know how to move," Klok says, adding the struggle that ensued as both her and Gloria pulled in opposite directions was a complete surprise. "She just caught me off guard."

Klok twisted over Gloria to reach the call bell at the head of the bed, a motion that strained her neck and injured her lower back in one fell swoop. She maintained that position and struggled to hold Gloria up for at least five minutes, waiting for colleagues to arrive and help. The now 51-year-old mother of four knows that's what did her in, but admits her focus at the time was Gloria's needs, and not her own. Four years after that injury, WSIB has now deemed Klok's neck a permanent impairment. She's still fighting to have her lower back injury recognized as equally problematic.

"I was not going to go to emerg," she recalls of that night in 2009. "Nurses always have bad backs, right? You're sore, you leave, go home, take a Robaxacet, you get up, it's fine, right?" Her colleagues convinced her to have the injury checked out, and she says "it's been a nightmare ever since." That's primarily because she feels she's had very little support from her employer, and suffered severe stress as a result of bullying by a manager at work. Klok was on sick leave immediately following the injury, then stress leave a few months later. She was laid off during her stress leave, and only this September resumed her role transitioning elderly patients from the hospital

PHOTO: CHRISTOPHER GRIFFITH/TRUNK ARCHIVE

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

to home. She fought through her union to get her position back, and is resentful for the lack of support. "I didn't do anything wrong," she says. "I did my job and got hurt. My whole life is messed up because of this…and I didn't deserve to be treated the way I was treated."

Klok admits she knew nothing about her rights when she injured her back. And she's not alone. "I've actually become a bit of an advocate and resource for other nurses who are injured and have no idea what to do," she says. Klok is currently doing her master's degree, and recently did a paper on surviving a workplace injury. She suggests the lack of knowledge among nurses could stem from the lack of research on the subject.

One comprehensive study that looked at the issue is the now eight-year-old *National Survey of the Work and Health of Nurses.* Conducted by Statistics Canada in 2005-2006, it found one in 10 nurses reported occasional or frequent injury on the job in the year before the survey. And about 37 per cent of nurses reported they had experienced pain serious enough to prevent them from carrying out their normal daily activities in the previous 12 months. A more recent systematic review of 89 existing studies on the correlation between nursing and lower back pain, conducted by nursing researchers at the University of British Columbia and published in the *International Journal of Occupational and Environmental Health* (September 2013), found a clear link between nursing duties and lower back pain. That link is sufficient scientific justification for reversing the burden of proof placed on injured nurses, the review's researchers note. The study found "…sufficient evidence exists of a causal relationship between nursing tasks and back disorders to warrant new policies."

SYSTEMATIC REVIEW FINDS A CLEAR LINK BETWEEN NURSING DUTIES AND LOWER BACK PAIN, AND THAT LINK IS SUFFICIENT SCIENTIFIC JUSTIFICATION FOR REVERSING THE BURDEN OF PROOF PLACED ON INJURED NURSES.

These are important research findings that speak to the connection between nursing and back injury, but they don't quite get to the heart of what Klok and others suggest is a bigger issue: an acceptance of back injury as commonplace in the profession. Klok is guilty of it herself, and considered simply working through her pain. She says so many of her colleagues would do the same, and wonders if that attitude can be linked back to nurses' training days, and the implied message she remembers from nursing school: if you're injured, "suck it up."

That message to students may not be as prevalent today, thanks in part to educators like Anne Marie Lozinski. As a clinical tutor, she works one-on-one with two fourth-year McMaster University nursing students each term. She teaches them about good body mechanics (proper body movement that helps to prevent injury) in order to "…save my bright young nurses from injury."

Lozinski, who sustained a back injury in 2004, works in rehab, where she says nurses tend to understand back injury a little better because they consistently see patients who have mobility issues. "On this floor, we're kind of blessed because we have physiotherapists and occupational therapists, and they work with us on transfer techniques," she explains.

Avoiding injury is all about moving properly, Lozinski explains. "Even my own injury was poor body mechanics," she admits. While giving a patient a shower, she "…twisted to do what I was doing…I should have bent at my knees, but I bent at my waist and twisted…which is never the right thing to do with your back."

Unlike Klok, Lozinski's experience post-injury was a little more positive. She was lucky enough to be in the right place at the right time, and shifted from the bedside to a more administrative position in 2007. She is now known for her consistent reminders to fellow staff to "…always be mindful of how you're moving, whether you're transferring a patient, washing them in the shower, or making a bed." She's also known for her advocacy to institute mandatory training each year on proper body movements and transfer techniques. She admits that injury is sometimes not preventable, because it's an unexpected movement on the part of the patient. But, more often, it's about understanding patients' limitations.

"You can underestimate how much assistance they need," she explains. "You're busy, your colleagues are busy, and you don't want to bother them to help you. You think 'I can do it myself,' and then you find out you can't, and you're stuck, holding someone who's not able to bear their weight."

Lozinski admits that when she injured her back, she had just come off an evening shift, and returned to work for a day shift less than eight hours later. She was physically and mentally drained, and says the muscles that should have engaged to protect her back were fatigued from overuse and lack of rest. "You make decisions spur of the moment, then you regret them," she says.

York region public health RN Patricia Ono understands how easy it is to regret a decision that changed things forever. She was a new grad working in acute care when she first hurt her back in the 60s. Young and naïve, she entered a patient's room and decided not to turn on the light and wake the gentleman in bed. She went to pull a lever to adjust his position, and yanked the wrong one, pulling her back out instead. She compounded the injury by continuing work, and when a large gentleman later grabbed her arm to pull himself up, she collapsed on the floor and couldn't stand up. "As a patient, you're not always aware…that you're not helping the person helping you," she says. "You're just concentrating on getting out of bed."

Although more comprehensive policies that address the link between nursing duties and back injury are recommended by some researchers who have delved into this issue, Ono says the onus is often on the nurse. "You have to think all the time," she advises. The first question she asks herself in any situation is 'how am I going to do this with the least amount of stress on my back?' People who haven't injured their backs don't understand this, but it's the single most important piece of advice she gives to young nurses. Sharing it with a broader audience is the reason she came forward to share her story.

"I used to have a head nurse who would say, 'if you think with your head, you'll save your feet,'" Ono recalls. She's altered that motto given her lived experience. "If you think with your head, you will save your back." **RN**

KIMBERLEY KEARSEY IS MANAGING EDITOR FOR *REGISTERED NURSE JOURNAL*.

RN PROFILE

BY DANIEL PUNCH

Rural nursing a perfect fit for ambitious NP

CONNIE FOSTER'S TRAJECTORY FROM PSW TO NP SHOWS FOCUS AND DETERMINATION PAY OFF.

WHEN CONNIE FOSTER PERFORMS the works of Beethoven or Bach on the piano, her busy life slows down.

Her eyes scan the sheet music and her feet push gently on the pedals. She plays deliberately with one hand, furiously with the other.

It may sound strenuous, but for Foster, it's leisure time.

"I just love playing the piano," she explains. "You're doing multiple things at the exact same time, and it changes (from one second to) the next…"

That pretty much describes life for the 49-year-old nurse practitioner, whose resume reads a bit like a directory of health-care professionals. Having been a PSW, Red Cross homemaker, RPN, RN and most recently, nurse practitioner, Foster has developed her career as a health professional, all the while holding down two or three jobs at a time and raising three children.

Foster's career has spanned the Muskokas and came full circle in a sense in 2011. She was hired as nurse practitioner/manager at the nursing station in Moose Deer Point, the small First Nations community where her mother and grandmother grew up, and where Foster spent her childhood summers.

As the only NP on site, she provides health care for 250 First Nations residents and a scattered population living among the isolated woods and islands along the shores of Georgian Bay. Living in such a remote community creates large barriers to transportation, and Foster must often pick up and drop off patients.

Due to the region's aging population with complex chronic-care needs, Foster's health-care team quickly outgrew the original nursing station. She watched a visiting mental health counsellor forced to do charting in his snow-covered car in the dead of winter and was spurred to action.

Foster formed a committee aiming to open a new, larger nursing station in Moose Deer Point. After nearly two years of searching, a house on Georgian Bay came available. Foster viewed the house and stayed up all night writing a proposal for the next day's chief and council meeting. Her proposal was approved, the house was donated by the Moose Deer Point First Nation, and the new health centre/nursing station opened this past October.

The larger space will allow the team to take on new patients and expand services to include acupuncture, traditional healing, and an Ontario Telemedicine Network link that lets patients see health-care professionals from across the province.

Three things you don't know about Connie Foster:

1. She loves fast cars, and has her eyes on a 2004 Chevrolet Corvette.
2. She drives around Moose Deer Point blasting classical music with her windows down to scare off bears that might wander onto the road.
3. She is taking Ojibwe classes.

"I really feel being in a rural community, where access to care is tougher, is where I can make a real difference," Foster says. "For me, it's about finding the gaps in service and what's missing. I want to be the one to make those changes."

Foster was a young mother in Burk's Falls when she first considered a career in health care in 1983. Many of her elderly neighbours received home care, but she noticed they also needed help running errands or fixing dressings between nurse visits.

"I ended up filling in the gaps," she says. "It was just a natural progression and I loved caring for people, especially those down and out on their luck…I could relate."

She applied for a PSW position at an area nursing home with no formal qualifications, but eager to do the required training. Before she knew it, she had positions at two nursing homes. With each step towards her current role as nurse practitioner, Foster always held her previous job(s) while studying for the next.

Throughout her work and studies, she found time to do occasional fly-in nursing to northern aboriginal communities. She was even called to duty on a recent vacation flight to Mexico, caring for a man who fell and gashed his chin on the washroom sink.

Health care never takes a day off, and neither does Foster.

"I was always thinking 'what's next?'" she explains. "Every time I reached my goal, I would be thinking one step further." **RN**

DANIEL PUNCH IS EDITORIAL ASSISTANT AT RNAO.

OF POLITICS AND POVERTY

Community led consultation gives members of the public a chance to talk about the impact of public policy on their lives, and to urge politicians to rethink strategies that aim to lift vulnerable populations out of poverty.

BY MELISSA DI COSTANZO

PHOTO: iSTOCK

Eight years ago, Tracy Mead's physician suggested she leave her job as a manager in a security firm as the stress it caused her was too great. Mead took the advice and suddenly found herself unemployed. Shortly after she left her job, she lost her apartment. She relied on social assistance and unemployment insurance to stay afloat. Ashamed to go to a food bank, and unaware of the support services available to her, Mead says she "starved (alone) in a room."

Several years passed before she learned her municipality provides cash for a transit pass to social assistance recipients who volunteer their time. In 2008, Mead began to help out at various organizations, including Toronto's South Riverdale Community Health Centre. As a volunteer, she helped to form the centre's *Health and Strength Action Group*, which advocates for increases to social assistance rates. She sits on the steering committee for *Put Food in the Budget,* and speaks at rallies to further advocate for poverty reduction. "I'm still hungry, but now, I'm hungry for change," she says.

Mead was one of 10 speakers who shared their lived experiences during a September panel discussion in Toronto entitled *Investing in a poverty-free Ontario: A community led consultation*. She opened up about a wide range of public policies, as did Madonna Broderick.

Broderick, who is in recovery related to mental health and addiction challenges, lived in poverty for almost three decades with no identification, no income, housing or health care. When she got sick, she was left with "no choice but to wait it out." In 2000, she entered a detox facility and was connected with a family physician who provided care without barriers. In previous instances, she says she was denied care because she didn't have a health card, and was unsure how to obtain one. "My doctor takes time to treat me like a human being, not a drug addict," she says.

Broderick wants to see better health-care coverage for people who may not have regular access to providers. Free clinics and prescriptions for low income families would go a long way towards helping those living in poverty, she says, adding it would allow for consistent care that could save lives. "What happens to people out there who get sick and have no coverage? It's simple. They die," she said during the panel presentation.

Working for Change, an organization that highlights the importance of work in the lives of those who have been marginalized by poverty and mental health issues, partnered with RNAO to co-chair the September event in collaboration with 16 other organizations, including: Income Security Advocacy Centre; ODSP Action Coalition; Ontario Federation of Indian Friendship Centres; Ontario Non-Profit Housing Association; Social Planning Toronto; and Workers' Action Centre.

The goal was to provide politicians and the public with the opportunity to learn about the impact of current public policies, and the urgent need to accelerate efforts to address poverty.

"Nursing is about supporting people to stay healthy," explains RNAO Senior Policy Analyst Lynn Anne Mulrooney, a key organizer for the event. "And you can't be healthy if you don't have a decent, livable income and a roof over your head."

"Many nurses see...the impact of poverty on health. As health professionals, their voices are respected when they speak out on public issues," says Jacquie Maund, policy and government-relations lead with the Association of Ontario Health Centres. Maund was moderator for one of the panels at the event.

"Whether...writing a letter to the editor, meeting with a local MPP, or adding expertise to local anti-poverty groups, nurses can help keep the issue of poverty and health on the political agenda," Maund adds.

Michael Creek agrees. Formerly homeless, Creek is now director of strategic initiatives at Working for Change, and says nurses' leadership has had a tremendous impact on government accountability for poverty reduction, and "...will play a critical role as we start to build the province that we all want."

The panel discussion came on the heels of Ontario's announcement regarding the renewal of its poverty reduction strategy, *Breaking the Cycle*. One aspect of the renewal was public consultation with individuals and organizations – these wrapped up in October – to help inform and shape the renewed strategy, which has not yet been released.

The government's original strategy, which launched in December 2008, set out to reduce the number of children living in poverty by 25 per cent over five years. It included an increase to the Ontario Child Benefit (OCB), funding investments to support education and early learning, and various community initiatives, such as the *Youth Opportunities Strategy* to give kids in priority neighbourhoods more access to jobs and training.

The government is investing $400 million over the next three years to fund improvements to the social assistance system, including increasing support by one per cent for some adults receiving Ontario Works (OW) and Ontario Disability Support Program benefits. Single adults on OW are receiving a top-up of $14 per month, says Mitzie Hunter, Parliamentary Assistant to the Minister of Community and Social Services. "Our government is committed to reforming social assistance, and to providing greater economic opportunities and fairness to lift more people out of poverty."

The Liberals say that despite a "difficult economic climate, more

Panelists (L to R, back): Avvy Go, Colour of Poverty-Colour of Change; John Plumadore, Federation of Metro Tenants' Associations; Liberal MPP Mitzie Hunter; Mike Creek, Working for Change; PC MPP Toby Barrett; RNAO CEO Doris Grinspun; NDP MPP Cheri DiNovo; and (L to R, front) John Campey, Social Planning Toronto; Teala Quintanilla, Ontario Federation of Indian Friendship Centres; Madonna Broderick, Women's Speak Out; Dawnmarie Harriott, Voices from the Street; and Jacquie Maund, Association of Ontario Health Centres.

than 47,000 children and their families were lifted out of poverty" in the first three years of the strategy.

In an August open letter to Premier Kathleen Wynne, RNAO CEO Doris Grinspun and RNAO President Rhonda Seidman-Carlson wrote that there are "still a staggering number of children (383,000) who live in poverty. More than 573,000 households in our province are 'food insecure' or lack basic access to nutritious food in sufficient quantities to maintain good health." The letter also reminded the premier that single adults on OW still face the brunt of government inaction by being forced to live on only $626 per month.

RNAO is calling on Wynne to: increase the minimum wage; change Ontario's social assistance system to ensure it reflects the actual cost of living; improve access to affordable and supportive housing, and address homelessness; reverse cuts to the child dental care program and extend it to adults in need; provide access to high-quality, not-for-profit child care; and ensure effective training and workforce development opportunities are available.

Hunter represented the Liberals at the September event, while MPPs Cheri DiNovo (NDP) and Toby Barrett (PC) provided responses on behalf of their parties. "There is no excuse for poverty. Poverty is an aberration. It is an abomination. It is unethical," DiNovo, critic for community and social services, said. Challenging the government, Barrett said it's "...time to wake up the system (and) give it a bit of a shake."

Teresa Piruzza, Ontario's Minister of Children and Youth Services, provided some opening remarks at the event, acknowledging there is more work to be done to "...move that bar forward."

For more RNAO activity and resources on poverty, visit www.RNAO.ca/povertyaction

"Poverty is a complex issue," she said. "Different approaches are required to overcome different obstacles, and each community has specific issues and challenges." With a nod to several of the panelists with lived experience, Piruzza added: "We need to listen to people like you. (It) helps us better understand the reality of poverty in our communities."

Like Mead and Broderick, Dawnmarie Harriott shared details of her personal challenges. Now a program co-ordinator with Working for Change, the single mother fled an abusive relationship and was forced to leave a secure, well-paying job. Food, rent and baby-sitting bills ate away at her bank account. She became homeless and lived in a shelter. "With poverty come barriers and chaos," she said. Transportation costs only added to her woes.

Harriott says public transit must be affordable and accessible for people living with a low income. She acknowledges that transportation subsidies are available for work- or medical-related priorities, but when it comes to using public transit for trips to the grocery store, or to drop kids off at daycare or school, many are left to fend for themselves.

Although employed and earning a steady income, Harriott admits getting around is still a challenge. She wants to see the government create strategies that ensure "...transportation isn't a barrier for people to get to their jobs, their schools, and their health care."

Young mom Solange Wright spoke about the limitations of day-care subsidies. The 21-year-old became pregnant at 18. She was homeless and had no help with her son as she attempted to finish high school. Daycare wasn't always an option. Restrictions such as access and cost made it "...hard being a young parent," she says.

Mead, Harriott, Broderick and Wright agreed to share their stories as a way to speak out for those who are often voiceless. Their perspectives are valued and vital, says Grinspun. "The experiences of each of these individuals paints a clear picture of how it feels to live under the poverty line in Ontario," she says. "We must heed their advice to transform this province into one that can better support its residents. We can do better." **RN**

MELISSA DI COSTANZO IS STAFF WRITER AT RNAO.

The "real" truth about being a HUB fellow

In 2011, Rebecca Harbridge won a HUB Fellowship, and the opportunity to shadow RNAO CEO Doris Grinspun for a week. She describes the experience as invigorating, empowering, energizing, and a highlight of her 25-year nursing career. **BY REBECCA HARBRIDGE**

My second-last HUB day started in the same hurried manner as the previous three. After encouraging hugs and kisses from my husband and young son, I fled out the front door in anticipation of the day's adventures with equal parts excitement and trepidation. As I was getting into my car, my son made his way toward me, announcing with great earnest: 'Mommy, you forgot your RN pin. You know how much that means to Miss Doris.' He clipped it to my collar and asked: 'Mommy, what does RN mean?' 'What do you think it means?' I responded. 'I know the N means nurse, but I don't know what the R means,' he admitted. Then, in a moment of recognition, he proudly announced: 'Real Nurse. That's what it means, right mommy?'

"That is exactly what it means," I told him with a sense of breathlessness. It would be several months before I would adequately process the extent to which this moment touched me.

I identify myself as a registered nurse, but am I a real nurse? What does it mean to be real in my profession? Am I authentic? Am I giving back?

An undeserving feeling burdens me as I ask these questions. My HUB fellowship has left me feeling honoured and proud, but at the same time, guilty. While I am a mid-career nurse, I am a relative newcomer to RNAO. Admittedly, membership was never on the top of my priority list as a student, new grad and young nurse because I was busy building and balancing life around my career.

In retrospect, I am saddened at my apparent lack of insight. By not reaching out to connect with fellow RNs, I had become one who "does the tasks of nursing." Five years ago, I joined RNAO after realizing my years as a nurse had slipped by.

Rebecca Harbridge (left) shadows CEO Doris Grinspun during a home office visit in March.

Membership has not only reignited my passion for my profession. It has reinforced a sense of urgency that will propel me through to the end of my career. I now realize that being a member is not only to be in the midst of greatness, but to recognize that you are the very greatness that makes nursing great.

As a HUB fellow, I have looked back at my career and into the future through a new lens. Instead of asking 'what's in it for me?' I have realized just how much I have to give back. I am no longer reaching for the top, and for something unattainable. I have learned that I am okay just the way I am. I am valuable and strong, and I can contribute to clients' wellbeing, communities, and my profession in ways that make a difference.

Each HUB fellow – including me – has experienced their own personal journey of learning. To future fellows, I say: be prepared for this experience to take you to places you might not expect. I can assure you the ride will be fantastic.

This fellowship – and Doris – has helped me find my voice to speak out for nursing and speak out for health. The experience has instilled the confidence in me that my voice matters, not only on its own, but in solidarity with 36,000 others. I'm grateful to have discovered the importance of political advocacy and strategy, but more importantly of being real when being real matters.

I now know – through Doris' example and my own critical reflection – what being a real nurse means to me. I wear my RN pin proudly, in part because my wise son asks me to, but more importantly because it reminds me that I have chosen to be a member of RNAO to give back to my profession in the truest sense. I wear my pin because I am a "real nurse," and for that, I am now confident and grateful. **RN**

Nominations for the 2014 HUB Fellowship opened in mid-November 2013, and will close Feb. 6, 2014. To find out more, visit www.RNAO.ca/awards

IN ADDITION TO BEING A PROUD HUB FELLOW, REBECCA HARBRIDGE IS REGION 5 REPRESENTATIVE ON THE RNAO BOARD OF DIRECTORS.

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AGM 2014

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AGM 2014

To access registration, reservations, and for more information, visit **www.RNAO.ca/AGM2014**

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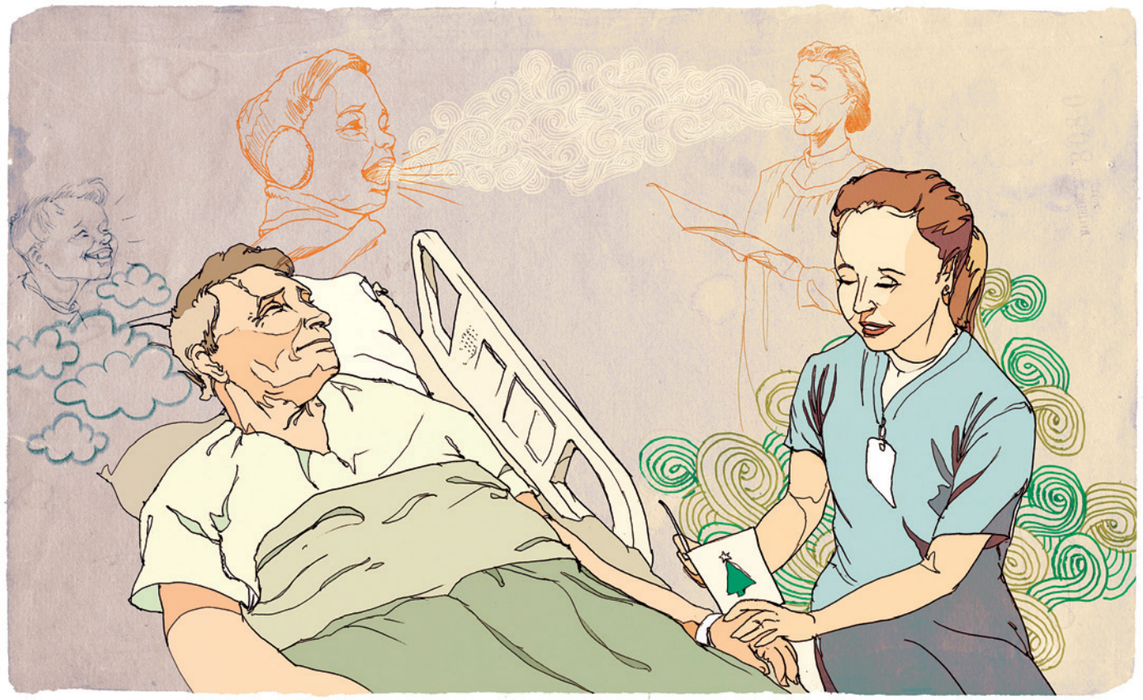
IN THE END

BY SHERYLL PAHATI



What nursing means to me…

Nursing is associated with a number of things, including accountability, leadership, regulated practice, interdisciplinary work, competence, skills and knowledge. It has evolved over centuries. But despite this evolution, caring, for me, remains the essence of nursing.

It was Christmas Day 2012, and I was caring for Arthur,* a 65-year-old gentleman who was admitted several weeks prior for treatment-resistant bipolar affective disorder. He was very tired, largely due to a recent heart attack combined with ongoing restlessness, lack of sleep and deficient food intake. He was pale and fragile, and kept his eyes closed most of the time, making it challenging to engage him. I asked Arthur if he knew it was Christmas Day. He did not answer.

DROP US A LINE OR TWO
Tell us what nursing means to you. Email editor@RNAO.ca

Although he was non-responsive, I knew he would appreciate having the greeting cards on his wall read to him. They had arrived earlier in the day from his sisters, brothers and friends. I described each card, read the message, and then started singing Feliz Navidad.

Arthur started singing the chorus with me, yet his eyes were still closed. His singing would fade after the chorus, but his toes would tap at the foot of the bed. Later that evening, I made a point of returning to Arthur's room to spend more time singing so he did not feel alone on the holiday.

Reflecting back, I remember thinking I was missing out on Christmas because I had to work that day. I can only imagine how difficult it must have been for Arthur, ill and away from his family and friends at this time of year.

RNs are frequently at the bedside, where we witness our patients' most vulnerable experiences. In mental health, being present with patients and empathizing with them demonstrates that we care enough to share in their illness experience. We help them feel supported.

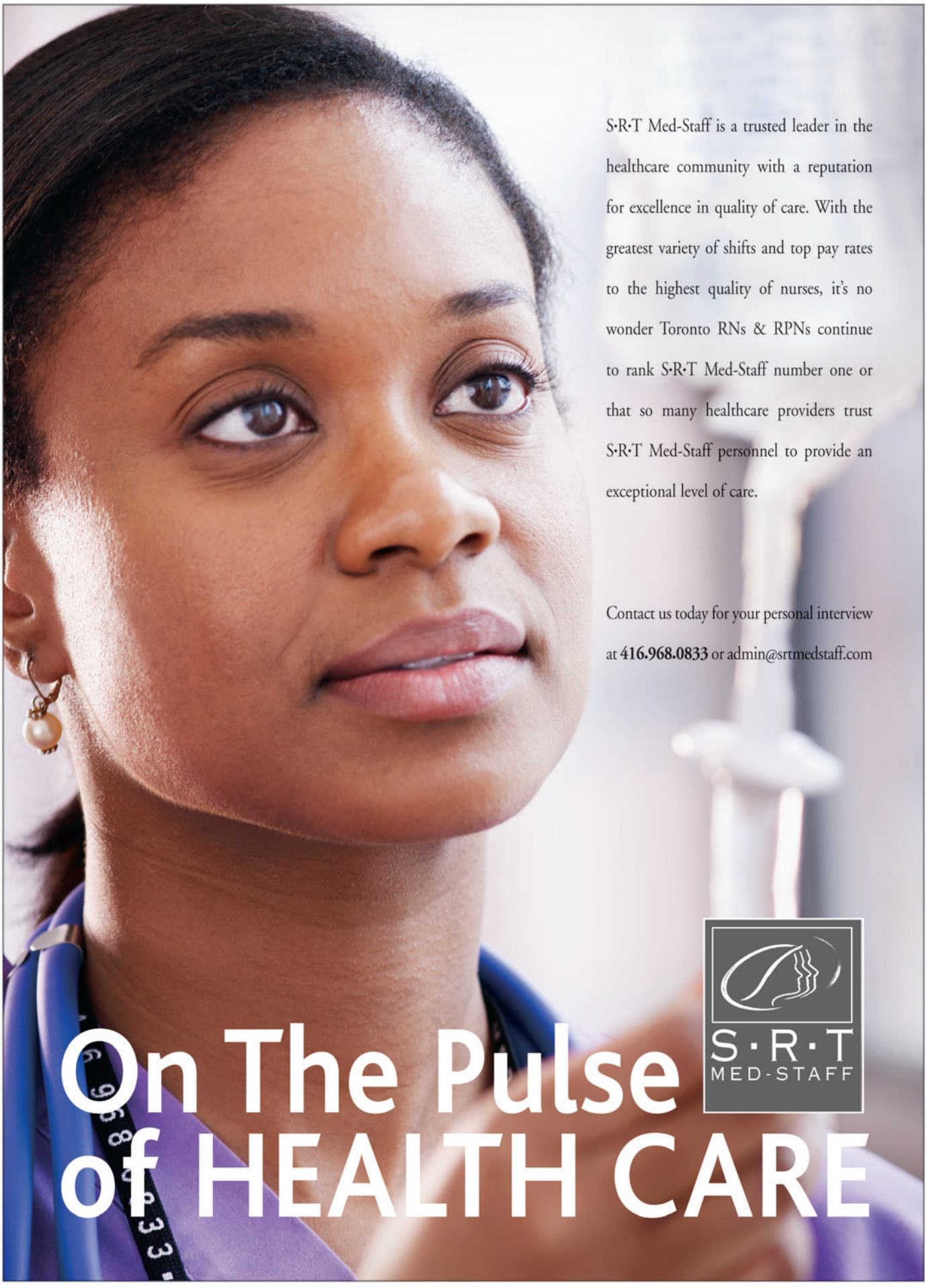
Not all patients who come through our door have family and friends to send them greeting cards or to visit them. Sometimes, nurses are the only people they can turn to, and the only people who will have the privilege to get to know their story. As an acute mental health nurse, I see several patients who express hopelessness because they feel stigmatized and abandoned by their loved ones. It's not easy work, but I believe caring motivates nurses to support individuals with mental illness, whose well-being can be compromised by other social determinants.

Nurses should not lose sight of the power of caring. It's the essence of what we do, and it's often the reason we strive to be accountable, and to be leaders. Regardless of our focus in the hospital, in the community, in government, or in academia, we do what we do because we all share the calling to care for our patients. **RN**

Sheryll Pahati is an RN for inpatient mental health services at Toronto's St. Michael's Hospital.

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

ILLUSTRATION: DAVE BARNES



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