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Registered Nurse JOURNAL

September/October 2004

FIRST MINISTERS' HEALTH SUMMIT

Inside and outside talks, team RNAO champions sustainable, not-for-profit health care.

Get published

Registered Nurse Journal **wants to hear from members interested in contributing to the publication.**

A few things to consider before submitting

- Look through back issues of *Registered Nurse Journal* to get a sense of the flavour of stories and the range of issues covered.
- Put yourself in the reader's shoes. What do you want to read about? Is your idea new, unusual, or the first of its kind? Is there something you would like to share about how to improve nursing practice?
- Talk to the communications department about the focus of your piece and its suitability for publication.
- Call if you have questions while writing your article. We're here to help you.

Five ways to get published

Write a feature article: We welcome feature submissions that address health-care issues facing the nursing profession and affecting RNs in all areas of practice. The criteria used to judge submissions: originality; significance and scope; timeliness; reader appeal; accuracy; and readability. Submissions should not duplicate material recently published in the magazine (1,000-1,200 words).

Send us your news and photos: Did your region, chapter or interest group recently engage in a special event or political advocacy in your community? What were the outcomes of these events that would be relevant to the membership? We welcome news stories and photographs from across Ontario. We want to share your success stories with other members (250-300 words).

Profile a colleague: One of the standing features in the magazine is the *RN Profile*, which provides readers with a glimpse into the lives of their colleagues. If you know a nurse who has made significant contributions to the profession, we'd like to hear from you. Take a look at back issues of the magazine to see who we've profiled, and to get a sense of the Q&A style of the feature (750-800 words).

Write to the editor: We encourage your comments about specific articles, RNAO activities or nursing and health-care issues. Write: Managing Editor, RNAO, 438 University Avenue, Ste. 1600, Toronto, ON, M5G 2K8, fax (416) 599-1926 or e-mail letters@rnao.org (200-250 words).

Use your student voice: Student opinions and perspectives are important to us. Send us information about student nursing activities or submit something for publication (750-800 words).

Once we get your submission: The editing process

Editing ensures authors' ideas are presented in the most readable manner, while retaining their personal style. It involves checking factual content, adding new information, deleting unnecessary material, and revising what remains to meet an accepted grammatical, spelling and writing style. All edited copy is returned to the author for final approval. Authors are responsible for all statements made in the article, including those made by the editorial staff. *Registered Nurse Journal* reserves the right to make the final decision on title, caption information and copy changes.

DON'T FORGET

- All feature articles, news submissions, letters to the editor and opinion pieces must be typed, double-spaced on standard 8 1/2 x 11 paper.
- All submissions should be provided in Microsoft Word or ASCII format on IBM compatible disk (e-mail is also acceptable), and should be accompanied by a hard copy.
- Include a covering letter with a brief biographical sketch of all authors along with your name, address, phone and fax numbers, and e-mail address.

For more information, contact RNAO's communications department at 1-800-268-7199 or 416-599-1925, or visit www.rnao.org and click on "About RNAO," "RN Journal," for links to 'writer's guidelines' and 'getting published.'

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Registered Nurse JOURNAL

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RNAO

FEATURES

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Celebrating our progress

On Oct. 6, RNAO member Barb Mildon spoke to *The Windsor Star* about nurses' renewed (but cautious) optimism that after years of political neglect, the profession is slowly beginning to mend. Kudos to Barb for pointing out the positive results that are beginning to flow from nurses' unprecedented advocacy work, and for sharing her "glass is half full" outlook with the media.

Sometimes in our push for change, we focus only on the pitfalls of our health-care system and ignore progress we've made along the way. It might serve us well to follow Barb's lead and reflect positively on even small steps forward, rather than remain skeptical – or worse, cynical – that change will ever happen at all. After all, new health and human resources funds are starting to flow for nurses and the public they serve. It would appear nurses are not without their powers of persuasion.

In this issue, our president's column and cover feature report what is missing in the recently minted health agreement, but acknowledge the positive outcomes of September's First Ministers' meeting in Ottawa. In fact, RNAO is pleased with the federal government's predictable, long term and adequate funding for health care – a fundamental improvement and foundation on which to renovate and expand health services.

In our feature about the new requirement for BScN as entry to practice in Ontario, RN Pat Patterson examines nursing students' positive perspective on change. They don't view this essential educational advancement as cause for upheaval or protest, but rather as a reflection of the new health-care environment within which they will become vital players.

As anyone involved in political action and advocacy knows, new human needs are always emerging and with them calls for renewed action and improvement. I guess that's what drives RNAO to continue to speak up for health and speak up for nursing.

But it's nice to stop every once in a while to celebrate positive change, and perhaps pat ourselves on the back for being part of that transition from old to new, and from good to better.

Kimberley Kearsey
Acting Managing Editor

It takes a team: RNAO covers the bases and hits home run for health at Summit

In the six months I have served as your president, I have witnessed again and again what happens when all the arms and legs and heads and hearts of your association work together in common cause: collectively we move the yardstick on a wide array of health-care issues that matter most to Ontarians. Whether it is our coordinated calls for a ban on competitive bidding for home care or our harmonious efforts to halt further for-profit health services, our strategic and synchronized approach is working to help influence political action and improve public policy.

The recent *First Ministers' Meeting on the Future of Health Care*, held in Ottawa September 13th to 15th, is a case in point. All members of the RNAO team worked in lock step with one another, from the staff who joined me and executive director Doris Grinspun in Ottawa, to local members who participated in events around the summit, to acting executive director Irmajean Bajnok and home office staff who offered advice and issued action alerts to contact the prime minister and premier, to members who responded quickly and intelligently to them, and to other members who spoke to the media after the deal was sealed.

With Doris working inside the room where the negotiations were unfolding and me working outside with the media and our coalition colleagues, we all complemented and supported each other's efforts to send a strong and clear message to the premiers and prime minister to seize the moment and secure an agreement that would protect, strengthen, expand and sustain our publicly funded, not-for profit health-care system.

And in the end, we did emerge with an agreement – when there might have been none – an agreement which, despite its weaknesses and sins of omission, does reinvest in, and expand, our health-care system. The debate over funding is over for now; we must turn immediately to implementing long-overdue health-care reforms. For an analysis of the agreement and an on-location inside account of how your tag team president/executive director tried to influence the outcome of the Health Summit, check out the cover spread of this issue of the *Registered Nurse Journal*.

"We all supported each other's efforts to send a strong and clear message … seize the moment and secure an agreement that protects, strengthens, expands and sustains our not-for-profit health-care system."

Of course, RNAO's efforts on the federal/provincial/territorial agreement did not start in Ottawa in September. Your association had weighed in early and often in the months leading up to the Health Summit. We laid the groundwork in the spring with the meeting of the finance and health ministers in Toronto where we called on the first ministers to open up the negotiations to the public – which the prime minister subsequently did. As I insisted: "This is about nation building, and you cannot build a nation behind its citizens' backs."

Throughout the summer, we continued to cite the latest studies exposing the inefficiencies and inequities of for-profit health care and to call for an expanded health-care system with stable and adequate funding for home care, primary care, elder care, and health-care professionals. When the first ministers met in Niagara-on-the-Lake in preparation for the summit, we reminded them of those imperatives. And at every opportunity, we urged the newly elected prime minister to attach conditions to any federal funding given to the provinces for health care. We even sent him negotiating advice on this via a memo/news release just before the summit began, urging him to heed the evidence on for-profit health care and use federal funding as a stick to stop it.

But just as our work didn't start at the summit, so too it didn't end with the summit. We must continue to push for an end to further for-profit health care. And given the absence of any real requirements to account for how the new federal funding flows and the lack of penalties for non-compliance or missing targets, it is more necessary than ever for RNAO to work with its coalition partners and the public to see that the prime minister and premiers follow through on the commitments they made in September.

As we monitor where the new investments are going, we will work with the government, other health-care stakeholders and the public to translate the words and the resources into effective and comprehensive health-care services that improve the quality of life for all Ontarians. And I know that, once again, I can count on all the arms and legs and heads and hearts of this fine association to work together to do their bit to move the bar even higher in our pursuit of healthy public policy.

JOAN LESMOND, RN, BScN, MSN IS PRESIDENT OF RNAO.

Mailbag

Cover illustration misconstrued, misleading

Re: East meets west, July-August 2004

I am writing to express my horror and disappointment on viewing the cover and page 11 of the last issue of *RN Journal*. The representation of a baby bottle is a blatant violation of the World Health Organization (WHO) *International Code of Marketing of Breastmilk Substitutes.*

It is incredible to me that my professional organization would permit such a blatant violation, when at the same time RNAO has recently developed and published wonderful best practice guidelines on breastfeeding.

It is absolutely essential that there be an immediate and formal retraction, as well as an apology to all registered nurses and health-care professionals, to say nothing of the breastfeeding mothers and babies who have worked to promote breastfeeding.

Martha Hackney, RN
Toronto, Ontario

The cover page of the July/August *RN Journal* may have unintentionally breeched the WHO code in relation to the marketing of breast milk substitutes. I believe the item illustrated may be meant to be a dropper for complementary therapies but it may be mistaken for an infant bottle.

Claudette Holloway, RN
Scarborough, Ontario

Publisher's response: *Claudette Holloway is correct that our July/August cover illustration included an image of a dropper bottle, not a baby bottle. RNAO strongly supports the WHO code and regrets any misunderstanding this illustration might have caused. RNAO will continue to advocate for healthy children through breastfeeding, and apologizes for any offence taken as a result of our July/August cover on complementary therapy.*

Stephanie Futher, RN, BScN, MAEd
1944-2004

Peacefully, with her husband Bill at her side, RNAO member Stephanie Futher died from pancreatic cancer at the Freeport Health Centre of Grand River Hospital on May 22. She was 59 years old.

Stephanie's membership at RNAO dates back to 1968. Since 2001, she served as a member of RNAO's provincial nominations committee.

Stephanie graduated as a registered nurse from Toronto Western Hospital in 1965. She received her Bachelor of Science in Nursing (BScN) from McGill University in 1968, and achieved a Master of Arts in Education from Central Michigan University in 1992. She taught nursing at Conestoga College for over 35 years. A strong volunteer in her community, Stephanie was co-founder of the Elmira Cooperative Nursery School, past-president of the Elmira Curling Club, charter member of the Woolwich Community Lions Club, and a volunteer at St. Mary's Hospital for 15 years.

Stephanie was well respected by both colleagues and students at Conestoga College. In 1991, she was nominated for the *Aubrey Hagar Distinguished Teaching Award*, and in November 2002, her exceptional contribution to nursing and the nursing program at Conestoga College was recognized with a *Special Nursing Excellence Award*. This award was created by a faculty colleague when Stephanie humbly declined a nomination for an RNAO recognition award that same year.

In honour of her contribution to the nursing program at Conestoga College, the *Stephanie Futher Memorial Bedside Nursing Award* was established with donations from colleagues, friends and family. Qualification criteria for the award will be determined later this year.

RNAO sends its condolences to Stephanie's family and friends. We will miss her contribution to the association, and to the profession. **RN**

Insurers, not OHIP, cover integrative CT therapies

Re: East meets west, July-August 2004

While I am very pleased with this article, I wish to make an observation (about my contribution as one of the interviewees for this feature). I am a subcontract nurse in independent practice with more than 100 patients who are primarily from auto or work-related accidents. The fee for service comes from the patients' insurer, not from OHIP. I do not wish nurses to be misled in reading the article.

Angela E. Peters, RN
Windsor, Ontario

WE WANT TO HEAR FROM YOU.
Please e-mail letters to letters@rnao.org or fax 416-599-1926.

Charting an ambitious course for the next six months

In my last column, I reminded you of the many benefits that RNAO membership brings, such as personal and professional growth, awareness of current health and nursing issues, and political savvy and action. As your executive director, I too have reaped the personal and professional rewards that RNAO has to offer.

Now, with the support of our president Joan Lesmond, immediate past president Adeline Falk-Rafael and the board of directors, I will be taking a six-month sabbatical to complete my doctoral dissertation. In my absence, Irmajean Bajnok, director of RNAO's Centre for Professional Nursing Excellence, and the staff at home office will ensure the association remains influential, vocal and visible on all health and nursing policy agendas.

Since the mid-90s, RNAO has endeavoured to ensure the voice of RNs and RNAO is heard and carefully considered by government, politicians, employers, unions, educators, health-care and community organizations, and the media. We are at the forefront and on the front lines of nursing, health care and social policy. We are behind the scenes and around decision-making tables, before legislative committees, royal commissions and at first ministers' summits. We are in front of the media, in the corridors of power, and on the streets of protest.

This recognition and presence brings with it even greater responsibility along with the opportunity to embrace broader social agendas. To extend the reach and range of RNAO's influence, RNAO staff will use the next six months to work on initiatives such as embracing diversity, strengthening the association's and the profession's identities, and expanding our roster of professional development opportunities and resources.

RNAO's Health and Nursing Policy Department, with direction from our board of directors, will develop a framework for action on embracing diversity using the *Ontario Human Rights Code* as a guide. There are many tough issues – race, sex, colour, ancestry, place of origin, ethnic origin, marital status, same sex partner status, sexual orientation, age, disability, citizenship, family status or religion – that we need to courageously address. This framework will build on RNAO's 2002 policy statement on racism and our Healthy Work Environment Best Practice Guideline on diversity currently in progress.

"Home office will ensure the association remains influential, vocal and visible on all health and nursing policy agendas."

The policy department will also conduct a systematic review of any remaining barriers and the necessary solutions to achieve the "70 per cent solution" that will see at least 70 per cent of all RNs in Ontario working full time. This is imperative if we are to resolve the nursing shortage. It is also vital for senior nurses who wish to work full time and for new grads – well over 90 per cent of whom aspire to secure full-time employment.

At the same time, the communications team will be working to secure even greater recognition of the association's visual identity. Since RNAO's current logo was introduced in 1989, it is inspiring to know that most nurses, politicians, reporters, employers and decision-makers recognize our logo and colours, and know what RNAO stands for – literally and figuratively.

And just as we are strengthening RNAO's visual identity, we are taking steps to help RNs across Ontario present a unified professional identity. This year, every new and renewing member will receive a complimentary RN pin as a token of our appreciation for your continued trust and support. We hope you will wear the pin proudly, opening a dialogue with your colleagues about the importance of RNAO membership and encouraging others to join the RNAO family.

Indeed, there has never been a better time to join RNAO. From the Healthy Work Environment Best Practice Guidelines project, to the association's inaugural policy institute coming this November, to the unprecedented success of the clinical Nursing Best Practice Guidelines Program, your professional association offers an extensive slate of workshops, conferences and practice tools to keep you at the forefront of nursing.

Without a doubt, RNAO is stronger than ever – more than 20,000 strong. We will steadily and strategically continue to increase our capacity to provide professional development services, practice tools, research, government relations and communications to help you and your professional association excel. With your ongoing support, we will continue to exercise our commitment to improving medicare and nursing for the public and for nurses. I urge you to renew your membership before Oct. 31 and invite colleagues to join RNAO.

I look forward to being back at the helm with president Joan Lesmond on March 1, reconnecting with colleagues and meeting the many new members of the RNAO family. Regards.

DORIS GRINSPUN, RN, MSN, PhD (CAND), O.ONT, IS EXECUTIVE DIRECTOR OF RNAO.

by **Jill Shaw**

Nursing in the news

RNAO & RNs weigh in on . . .

RNAO speaks out on privatization, pharmacare

Canada's health-care system was put through the political wringer once again this summer as the 13 premiers and territorial leaders descended on Niagara-on-the-Lake to develop a health-care plan for their September meeting with Prime Minister Paul Martin. While the meetings took place behind closed doors, RNAO made its presence known by calling for transparency in the debates. (*Welland Tribune, Toronto Sun, Global TV – Toronto*, and *CBC Radio One - Toronto & Sudbury*, July 24, 27, 28). RNAO also urged the premiers to halt the privatization of health care on *CBC Radio One – Toronto* and *CH TV* (July 28).

As the meetings ended, RNAO applauded the premiers for their national pharmacare proposal, but quickly pointed out that the lack of commitment to a not for profit health-care system must be addressed at September's health summit. Executive director Doris Grinspun told the *St. Catharines Standard*, "We are very distressed they could not stop privatization," (July 31). *The Kenora Daily Miner & News, CITY TV - Toronto*, and *CBC Radio One - Toronto & Ottawa* (July 30-Aug. 3) also covered RNAO's reaction.

(Above, left to right): RNAO executive director Doris Grinspun, Premier Dalton McGuinty, and RNAO president Joan Lesmond discuss health-care priorities at the Council of the Federation in Niagara-on-the-Lake (July 28-30).

Saving VON Niagara

RNAO members spoke out against the decision by Community Care Access Centre Niagara to end VON's contract to provide in-home nursing services.

- **Roseann Norton** said the decision has devastated patients. "They're feeling overwhelmed. They're shocked, there's disbelief, there's tears. Staff are having to spend a lot of time consoling them." (*Welland Tribune*, July 6)
- At a rally to protest the CCAC's decision, **Evelyn Earle** hoped Health Minister George Smitherman would hear VON's concerns and intervene. **Debbie Charbonneau** called the rally the first step in the fight against the government's request for proposal process. "It's about money, not about patient care – and certainly not about the community." (*Welland Tribune*, July 9)
- **Judith Shamian**, VON Canada president and CEO, and an RNAO past-president, told rally participants the request for proposal process puts patient care at risk, and reduces job security for nurses (*Welland Tribune*, July 8).

Helping Africa cope with HIV/AIDS

In August, RNAO president **Joan Lesmond** visited the southern African country of Lesotho as part of an Ontario Hospital Association fact-finding mission on HIV/AIDS. The group is investigating how Ontario's hospitals and health-care professionals can assist the small country in its battle against the deadly virus; their efforts received coverage across Canada.

- **Lesmond** told the *Globe and Mail* she knew of many nurses ready to help. "People want to help, but they need a vehicle, and that's what we want to give them, a way they can come and help." (Aug. 7)
- **Lesmond** told the *Scarborough Mirror* RNAO has always been interested in easing the AIDS crisis (July 17).
- **Lesmond**'s trip was also covered by *CBC Radio One - Toronto & Sudbury* (Aug. 18).

For complete versions
of any of these stories, contact
Jill Shaw at jshaw@rnao.org.

Burning the midnight oil

RNAO member **Lynn Muir** and president **Joan Lesmond** were featured on the *New RO – Ottawa* and the *New VR – Barrie* following the release of an American study that linked the number of overtime hours RNs work with an increase in medical errors (July 8).

Hospital funding

The provincial government's announcement of $470 million for hospitals drew reaction from RNAO members and executive.

- RNAO executive director **Doris Grinspun** told the *Globe and Mail* the funding announcement is good news because it is tied to providing full-time nursing positions (July 27).
- RNAO reaction was also covered by *Toronto Star, CBC TV - Toronto* and *CKWS TV – Kingston* (July 27).
- RNAO member **Wendy Fucile** said Peterborough Regional Health Centre needed to see the exact amount the hospital would receive before determining how much could be used to pay down the hospital's deficit (*Peterborough Examiner*, July 27).

Caring for patients at home

RNAO reaction to Health Minister George Smitherman's announcement of $103 million more this year for home care received province-wide coverage from the *Globe and Mail, Welland Tribune, London Free Press, St. Catharines Standard, Toronto Sun, Hamilton Spectator* and *Canadian Press* (July 5 & 6).

- **Doris Grinspun** told the *Globe and Mail,* "The research supports this, the public needs this, and health-care providers and communities across Ontario have been asking for this."
- **Lynn Coad** told the *Timmins Daily Press* the money will allow people to spend their final moments at home. "The ministry recognizes the need to invest and this money will broaden access. The end of life is a tender time." (Aug. 18)
- RNAO past-president and president and CEO of Saint Elizabeth Health Care **Shirlee Sharkey** authored a letter-to-the-editor chastising the premiers and territorial leaders for failing to establish a national home-care program at their July meeting. "Timely access to health care and information in the natural home environment is fundamental to medicare reform." (*Ottawa Citizen*, Aug. 11)

Battling virus outbreaks

- Following two patient deaths at Cornwall Community Hospital from C. difficile, RNAO member **Kim Peterson** told the *Cornwall Standard-Freeholder* there had not been an increase in the amount of the bacteria in the hospital, but it had become more potent (Aug. 10).
- **Laura McLachlin** said an outbreak of a suspected respiratory viral infection

Out & About

Above: On Aug. 2, RNAO president Joan Lesmond participated in a fact-finding mission to Lesotho, Africa. Invited by UN Special Envoy for HIV/AIDS in Africa Stephen Lewis, Lesmond (left), here with Dr. Thebelo Ramakapeg, Director, General Health Services, Lesotho, was among three Ontario delegates whose primary goal for the project is to twin hospitals in Ontario with hospitals in Lesotho.

Below: On Aug. 23, RNAO met with Ontario's Minister of Training, Colleges and Universities Mary Anne Chambers to discuss progress on BScN as entry-to-practice. From left: Irmajean Bajnok, director of RNAO's Centre for Professional Nursing Excellence; executive director Doris Grinspun; Minister Chambers; immediate past president Adeline Falk-Rafael; Ann Brokenshire, Provincial Nurse Educators Interest Group; and Judy Britnell, member-at-large, education.

The Toronto Star (July 21, 2004) *Letter to the Editor*

Ontario to buy private clinics: Talks held to make 7 MRI facilities public

Kudos to Premier McGuinty for recognizing the folly of for-profit health-care services, and taking action to bring seven private MRI and CT clinics into the public fold. In addition to repatriating the MRI and CT clinics, the Registered Nurses Association of Ontario (RNAO) urges government to go one step further and provide operational funds to run these medically necessary diagnostic services 24 hours a day, seven days a week.

There is compelling evidence against for-profit delivery of health-care services. We all know what happens when shareholders and investors call the shots in health-care delivery – we will pay more and see a decline in the quality of care. Proponents of privatization – such as Conservative leadership hopeful Frank Klees – should heed the lessons learned from the Tories' Cancer Care Ontario debacle before challenging the premier's decision to steer away from profit-driven health-care and invest in publicly funded, not-for-profit delivered Medicare.

There's no doubt that Ontarians will be better served by repatriated MRI and CT clinics and a policy of not-for-profit health-care delivery. Indeed, this is one "ideology" that registered nurses hope will prevail when federal, provincial and territorial leaders meet to hammer out a health-care deal.

Joan Lesmond, RN, BScN, MSN
President
Registered Nurses Association of Ontario

at Valleyview Home for the Aged forced staff to wear gowns, gloves, masks and goggles when treating infected patients (*St. Thomas Times-Journal*, Aug. 19).

Reporting gunshot wounds

RNAO member **Willi Kirenko** said she is concerned Premier McGuinty's plan requiring hospitals to notify police of a gunshot wound would compromise patient confidentiality and deter gunshot patients from seeking medical attention (*Chatham Daily News*, July 12).

Mandatory retirement

RNAO executive director **Doris Grinspun** told the *Toronto Star* that even if employees can work beyond age 65, it won't solve the nursing shortage because on average, nurses retire at age 59. "The problem is, the nature of the work is very heavy-duty." (*Toronto Star*, Aug. 21)

Childhood poverty

RNAO member, and founder of the *Pathways to Education* program, **Carolyn Acker**, said she is eager to bring the program to other areas, but more funds are needed to do so. *Pathways to Education* provides high-school students in Toronto's Regent Park with the resources they need to stay in school.
"We need a bottoms-up approach. Communities know what their needs and priorities are. The grass roots and the bureaucrats are going to have to meet." (*Toronto Star*, Aug. 4) **RN**

McMaster University researcher, P.J. Devereaux (right), speaks with RNAO staff and board members on June 10 about his groundbreaking study that calls for-profits the "cigarettes of health care: bad for health and costly." Originally published in the *Canadian Medical Association Journal*, the study found for-profit health care is of poorer quality and more costly than not-for-profit.

On Aug. 24, RNAO met with Health Minister George Smitherman to discuss strategies to achieve the "70 per cent solution" (that will see at least 70 per cent of RNs working full time) and the ministry's plan to introduce Local Integrated Health Networks (LHIN). Pictured left to right: Irmajean Bajnok, director of RNAO's Centre for Professional Nursing Excellence; executive director Doris Grinspun; Minister Smitherman; and president Joan Lesmond.

by Jill Shaw

RN brings healthy living to students

Why Nursing?

Each September, as teachers, students and parents gear up for a new school year, RNs like Sue Schnurr hit the halls of Ontario's schools. A public health nurse at the Middlesex-London Health Unit (MLHU), Schnurr is charged with keeping kids in the school system healthy.

Initially attracted to nursing because of its diversity, Schnurr obtained her BScN from the University of Western Ontario in 1977. She immediately began working at the Middlesex-London Health Unit (MLHU). She was assigned to schools in 1993; initially working in both elementary and secondary schools. Eight years later, when MLHU restructured and asked nurses to choose between elementary or secondary schools, Schnurr chose to work in the elementary school system, promoting healthy living in 13 rural schools west of London.

Responsibilities:

Schnurr is a member of the MLHU's child health team, which develops health programming for kids between the ages of three and 14. Although the team works with many community groups, Schnurr's work typically takes her into schools.

While the amount of time she spends in each school varies, Schnurr will spend as much time as is needed to help a school achieve its goals and address any particular health issue it finds pressing or in need of attention.

Six of the 13 schools at which Schnurr works have "healthy schools committees" comprised of parents, teachers and students. Created several years ago, these committees identify lifestyle and health concerns for the student population. The committees discuss anything from clean bathrooms to the need for drug and tobacco education; however, Schnurr says it's the need for healthy eating and physical activity among children that has gained the most attention over the last five years.

According to Schnurr, childhood obesity can be linked to many factors, including a child's socio-economic status. Schnurr offers students from lower socio-economic backgrounds tips for healthy grocery shopping on a budget, and supports participation in the MLHU's *Families are Munching Program*, encouraging families to eat fruits and vegetables.

Name: Sue Schnurr
Occupation: Staff public health nurse, Middlesex-London Health Unit
Home Town: Appin, Ontario

To get kids moving, some schools have implemented the *Peer Leadership for Active Youth* (PLAY) program. Developed by an MLHU nurse and nursing students, PLAY recruits older children to instruct younger children in safe, non-competitive playground games. The health unit also encourages healthy living through other programs including *Healthy Eating Champions* (an MLHU program to introduce healthy food choices into schools) and *Walk to School Day* (an annual, international event to raise awareness of the benefits of walking).

Challenges:

Schnurr says one thing that would make her job easier is time.

"If I could go and spend even one day a week in each school, it's amazing what could be done," she says.

Schnurr says teachers currently provide most of the tobacco and sexual health education that was once the domain of public health nurses. Although she believes there is no substitute for an RN's expertise, giving teachers and parents a greater role in health promotion allows them to take greater responsibility for their child's care.

Memories of a job well done:

Schnurr admits the success of the MLHU healthy lifestyle programs has been overwhelming. With her help, one school became a Healthy Eating Champion by setting up a snack cart to sell healthy food choices to students.

"You could walk in at lunch and there would be a line of kids halfway down the hall waiting to purchase something from this cart," she says. "When you see stuff like that, it really makes you think, 'Oh wow, we really did something right.'"

The number of schools participating in active living programs is also increasing. Thanks to the health unit's marketing efforts, two thirds of all London-area schools participated in *Walk to School Day* last year, and more are beginning to participate in variations of the program including *Walking Wednesdays* or *Walking Weeks*.

Future plans:

With the new school year now underway, Schnurr says she will be busy recruiting members for the healthy schools committees, and promoting participation in programs like *Walk to School Day*. Despite the challenge of getting kids active in a sedentary world, Schnurr says small improvements in kids' lifestyles will make the biggest difference to their health.

"You do see some positive results … and you just think if I keep up with this eventually we'll have healthier kids and they're going to become healthier adults." **RN**

JILL SHAW IS EDITORIAL ASSISTANT FOR RNAO.

by **Sine MacKinnon**

FIRST MINISTERS'

Inside and outside talks, team RNAO champions sustainable, not-for-profit health care.

AS the First Ministers' Health Summit neared, a sea of representatives from organizations and advocacy groups from across Canada washed over Ottawa, spilling onto the grounds of the Conference Centre, and spreading out in search of an audience with the national media and federal, provincial and territorial politicians. Armed with evidence, arguments and agendas, they came to influence the outcome of an agreement intended, as the prime minister said, "to fix medicare for a generation."

RNAO president Joan Lesmond and executive director Doris Grinspun were there as well, working in a strategic and synchronized way to help shape an agreement they hoped would protect, expand and sustain medicare. The president worked outside the Conference Centre where the televised talks were held, providing a crucial link to the media and strategizing with groups advocating for stronger, not-for-profit health care, while the executive director worked inside the negotiating room, offering advice, expertise, and sometimes admonitions, to politicians, their staff, and senior public servants.

At the same time, members of the RNAO family worked in lock step to influence and improve public policy—from staff on site in Ottawa, to local members who participated in summit events, to the acting executive director and home office staff who offered advice and issued action alerts, to members who responded to them, to others like Caron Powell and Kathy Demaine who spoke to reporters after the deal was sealed.

To get a sense of what unfolded, we asked the president and executive director to share some of their insights into the summit.

A PAGE FROM THE EXECUTIVE DIRECTOR'S DIARY

Sunday, Sept. 12

• Arrive Ottawa around noon. Spot several premiers in hotel lobby. Joan and I shake their hands, wish them well, and lay out our expectations: in addition to increased, stable funding targeted to an expansion of reformed health services, we must strengthen nursing and ban further for-profit health care. We take every opportunity to convey our messages. We are kind of in their faces, quite frankly…
• Reporters interview Joan and me.
• Attend a Celebration of Medicare, organized by the Canadian Federation of Nurses Unions (CFNU), where the federal Health Minister speaks. Delighted to see Ottawa member Riek van den Berg. Talk with federal Health Minister, and premiers of Manitoba, Saskatchewan and Nova Scotia.
• Dinner with Joan, Lesley Frey (RNAO senior communication staff), Sheila Block (RNAO's Director of Health and Nursing Policy) to discuss messages for news release.
• Up late, strategizing with Joan, Sheila, Lesley and colleagues from the Canadian Health Coalition (CHC). Read tons of documents and review details of the Romanow Report!

Monday, Sept. 13

• Receive security pass and access to negotiating room where prime minister, premiers, and territorial leaders assemble with their delegations. RNAO is the only provincial association inside.
• It is awesome having a person inside and outside the room. That is hugely rich for us, and for all the others with whom we work. By moving fluidly between and among politicians, civil society groups, and the media, we assert more influence on the political and policy process.
• We are desperate by end of day because no premier raised the issue of privatization. Decide to do something to raise the issue. After brainstorming with staff, the CHC and other advocates, we come up with a great idea for a visual aid to flag the need to get for-profit health care on the negotiating table! We decide that as the premiers go in to the talks the next morning, we will hand them paper plates with the message: "Put it on the table…Stop Privatization."

Tuesday, Sept. 14

• As the Manitoba Premier heads in for breakfast, I beg him to raise the privatization issue. He assures me he will. (He did, and was the only premier to raise the not-for-profit issue). Meanwhile, Joan to welcome Premier McGuinty with the same request (he enters through another door ☹)
• I have direct dialogue with all the key players from Ontario, other provinces and territories, including premiers and ministers, senior political staffers and civil servants, strategizing and pushing our goals. I am able to hear their frustrations, and see where we agree and disagree. Very encouraged by our own premier's ability to keep his colleagues at the table (he is the Council of the Federation Chair). But disappointed Ontario didn't play an overt role in raising the not-for-profit issue.
• I offer advice to Ontario delegation. The minister pulls me out and wants to know where RNAO stands on pharmacare, and I assure him RNAO is absolutely supportive of it. I am so proud that our premier repeats the full-time strategy for nurses; we are clear-

RNAO executive director Doris Grinspun marches in rally during the Council of the Federation meetings in Niagara-on-the-Lake, July 28th to 30th.

HEALTH SUMMIT

ly leading the country on this one!

• I speak with Finance Minister Greg Sorbara, Health Minister George Smitherman, senior staff from the premier's and ministers' offices and senior federal bureaucrats about the importance of investments being tied to results. At times I feel I am assisting them, at others, encouraging or inspiring them, and at others, simply pushing them to stand up for medicare. I urge them not to walk away from the table.

• A couple of reporters interview me and Joan.

Wednesday, Sept. 15

• Televised talks break off as premiers and territorial leaders organize themselves into working groups to broker a deal away from glare of cameras.

• I speak with Global TV and OMNI about the dangers of failing to reach an agreement or reaching an agreement that reinvests in health care, but has no strings attached.

• Mingle, exchange views and analysis with reporters.

• Speak with ministers from other provinces and territories about our BPG program ☺

• Exchange views with ministers and senior political staff as I spend a nerve-wracking day waiting. We have too much invested not to get an agreement. Stakes very high.

• Disappointed deal-making happening in back rooms. We need public proceedings because the premiers and P.M. know where most Canadians stand, but we need to know where each of them stands.

• Lesley, Sheila and I work on news release (by noon Wed. I predict there would be a

(1) RNAO Ottawa member Riek van den Berg, left, joins president Joan Lesmond, federal Health Minister Ujjal Dosnajh, and executive director Doris Grinspun during a Celebration of Medicare event Sun., Sept. 12. (2) RNAO president Joan Lesmond stops New Brunswick Premier Bernard Lord to champion not-for-profit health care as he heads into Tuesday's negotiations. (3) Using a paper plate as a visual prop, RNAO president Joan Lesmond joins colleagues to implore premiers to "put it on the table: stop privatization."

deal. No way they could walk out without money. The only question: would there be strings attached from the feds to expand medicare and shrink privatization?)

Thursday, Sept. 16

• **2a.m.** Citytv's Adam Vaughan interviews me about whether the agreement will have sufficient strings attached. No! I say, and why… (I wish the answer were yes!)

• **3a.m.** Return to negotiating room where P.M. announces the federal government and first ministers have reached an agreement on a 10-year plan to strengthen health care. I rush to give agreement to Sheila and Lesley to fine-tune news release.

• **4a.m.** Speak with Premier McGuinty, congratulate him on his work as chair, and assure him RNAO will be following the implementation closely, offering solutions, and continuing to insist on no funds for for-profit health care.

• **4:16a.m.** Work with Lesley and Sheila to finalize news release: "RNs pleased First Ministers signed deal, but insist on enforcement mechanisms and that new funds go to patient care, not profits."

• **8a.m.** Travel home to be with family for Rosh Hashanah.

Building the foundation

RNAO's efforts to influence the outcome of the Health Summit did not start in Ottawa in September.

"From the moment we knew there would be a health summit, Joan and I knew we must be there," says RNAO executive director Doris Grinspun. Grinspun sees the association's comprehensive contribution to the Romanow Commission as the starting point in cementing RNAO's positions and messages into policy, political and public agendas – and ultimately into health-care agreements.

Highlights of RNAO's efforts in the run-up to the summit:

- **April 22-24, RNAO's Annual General Meeting**, featuring guest speakers Premier Dalton McGuinty and Commissioner Roy Romanow. Mr. Romanow challenges politicians to find the political will to protect and expand medicare. The premier accepts the challenge. RNAO speaks to media, and urges the PM to televise the health-care summit.
- **May 28-May 30** meeting of finance and health ministers in Toronto. RNAO president on site, urging politicians to expand publicly funded, not-for-profit health care. "Canadians are more committed than ever to universal, publicly funded health care that does not profit from a person's illness. They continue to identify medicare and access to registered nurses and other health-care providers as their top priorities," the president says in a news release. RNAO president appears on the New VR, urging first ministers to shore up system by insisting on not-for-profit health care.
- **May and June:** RNAO responds to latest study exposing the inefficiencies and inequities of for-profit health care and comments on how the nursing shortage hurts patient safety.
- **Federal election campaign**. RNAO publicly challenges politicians to sign *Medicare Protection Pledge*. RNAO produces and posts a comparison of the parties' platforms, and issues news release calling on the public to vote carefully after considering RNAO's evaluation.
- **Run-up to Council of the Federation meeting**. RNAO urges council to support a national ban on public-private partnerships (P3) to build hospitals, private hospitals, and for-profit MRI and CT scan clinics. "These will erode medicare's long-term sustainability," says Lesmond.
- **RNAO calls on council to televise proceedings**. "This is about nation building and you cannot build a nation behind its citizens' backs," says Lesmond.
- **July 28th-July 30th Niagara-on-the-Lake Council of the Federation meeting**. RNAO president and executive director on site, commenting on council's deliberations, lobbying premiers, and participating in events (OHC teach-in & rally/CFNU, Niagara Family Physicians news conferences). Niagara Chapter chair Marlene Slepkov and board member Paul-André Gauthier join in.
- **July 30, Niagara-on-the-Lake**. RNAO applauds decision to televise upcoming summit, supports the pharmacare plan, but faults premiers for failing to halt privatization.
- **Run-up to First Ministers' Health Summit, Fri., Sept. 10**. RNAO issues news release/memo to P.M., offering advice on upcoming negotiations. **RN**

First Ministers' Health Care Agreement

Report Card

September 2004

Subject	Grade	Comments
Stable Funding	A+	The funding agreement exceeds the amount originally promised by the Prime Minister. The new $19 billion base transfer will increase by 6% each year, ensuring predictable, stable funding, and enabling provinces and territories to undertake multi-year planning.
Accountability and reporting	D	The agreement is based more on 'trust' and an assumption that the public will hold governments to account. Since weak accountability facilitates privatization by stealth, Canadians will have to be diligent to ensure real accountability. Medicare is still on life support - not from lack of money - but because of weak controls on where and how the money will be spent. Follow the money!
Stemming the Tide of Privatization	D	The Agreement is silent on for-profit delivery of health care services. The proliferation of investor-owned, for-profit clinics acts like a viral infection in the body of Canada's public health care system. Commercialized health care reduces universal and equal access, increases costs and seriously diminishes quality of care.
Reducing Wait Times	C	The provinces agreed to reduce wait times by March 31, 2007 in the areas of cancer, heart, diagnostic imaging, joint replacements, and sight restorations. The real issue is how this will be done? Attempts to reduce wait times by allowing more for-profit delivery have failed wherever it has been tried. We need to reduce wait times by expanding the capacity of the public system.
Home Care	B-	First dollar coverage by 2006 for acute home care services will be provided. This is a very important step, however, there is still a long way to go before we have a comprehensive national program.
Elder Care	F	Despite an aging population and the increased demand for nursing home care, long-term health care was absent from the agreement. To ensure high quality care and equitable access, national standards for care and non-profit delivery are essential. Long-term care must become part of Medicare.
Pharmaceutical Strategy	C-	The agreement recognized the need for equity of access to essential medicines, cost controls, creation of a catastrophic drug plan, and other key elements of a national pharmaceuticals strategy. A Ministerial Task Force will develop and implement the strategy. There is no indication that governments are prepared to move quickly as they aren't scheduled to "report on (their) progress" until June 30, 2005. Unfortunately, this means that Canadians won't have expanded coverage for essential medicines any time soon. Citizens must work diligently to ensure the Task Force isn't hijacked by Big Pharma.
Primary Health Care Reform	D	The First Ministers think they are making significant progress on primary care reform, and that all they need to do now is to share information on best practices. This view is not shared by millions of Canadians who are in need of family physicians and are waiting anxiously for meaningful reform that establishes access to primary care on a 24/7 basis with interdisciplinary teams of caregivers. The Community Health Centre model has proven to be successful in delivering primary care in this way. It needs to be promoted.
Human Health Resources	C-	First Ministers will accelerate and expand the integration of internationally trained health graduates. Any reliance on this approach must not contribute to "poaching" health professionals from developing countries. Governments should implement the recommendations of health human resources studies already completed. Why spend over $7 million in funding health human resources studies and then ignore them?

Just the facts ma'am

TO participate in fact-filled debate about the impact of for-profit health care on the sustainability of the system and the quality of patient care, RNAO members should be well versed in the latest research, studies and evidence. For the facts on for-profit health care, go to:

- An RNAO analysis (http://www.rnao.org/features/election_2004_deveraux.asp) on recent studies headed by McMaster University researcher Dr. P.J. Devereaux. The series of studies found that for-profit health care is more costly and of poorer quality than not-for-profit health care.
- http://www.ecn.ab.ca/consumer/ for a report by Wendy Armstrong, Consumers' Association of Canada (Alberta). "Canada's Canary in the Mine Shaft: The Consumer Experience with Cataract Surgery and Private Clinics in Alberta." The report found that in locations with more reliance on private for-profit facilities to deliver publicly insured cataract surgeries and an optional privately paid second tier, Albertans were more likely to experience: longer waits for cataract surgery; more frequent out-of-pocket patient charges for physician recommended care; less value for money from suppliers and the public plan; decreased choice of cataract surgeons based on ability to pay; questionable compliance by surgeons with professional codes of conduct.
- http://www.chsrf.ca/mythbusters/index_e.php. for excellent fact sheets on the health-care system, produced by the Canadian Health Services Research Foundation.
- http://www.rnao.org/html/PDF/CMAJ_high_costs.pdf for a commentary by Steffie Woolhandler & David Himmelstein on the high costs of for-profit care.

A PAGE FROM THE PRESIDENT'S DIARY

Sunday, Sept. 12

• Arrive in Ottawa and do a live interview with CFRB radio in Toronto on health care and professional implications of mandatory retirement.

• Lobby premiers in hotel and later at CFNU event where local RNAO members lend their support. I engage in discussion with the federal minister of health and the premier of Saskatchewan.

• Impressed by the level of collaboration with so many different advocacy groups dedicated to protecting and strengthening medicare.

Monday, Sept. 13

• Spend time at the Public Health Response Centre, across the street from the Conference Centre, consulting other nursing and advocacy groups and monitoring talks.

• Attend a noon-hour rally organized by the

Aboriginal nurses respond to Health Summit

ON the opening day of the First Ministers' Health Summit, the Aboriginal health issues brought to the table provided a stark picture of the challenges faced by Aboriginal people across Canada. To begin to tackle those challenges, the federal government announced:

- An *Aboriginal Health Transition Fund* to enable federal-provincial-territorial governments, First Nations governments who deliver health-care services, and Aboriginal communities to devise new ways to integrate and adapt existing health services to better meet the needs of all Aboriginal peoples, including First Nations, Inuit and Métis.
- An *Aboriginal Health Human Resources Initiative* to increase the number of Aboriginal people choosing health-care professions; adapt current health professional curricula to provide a more culturally sensitive focus; and to improve the retention of health workers serving all Aboriginal peoples, including First Nations, Inuit and Métis.
- Programs of health promotion and disease prevention, focusing on suicide prevention, diabetes, maternal and child health, and early childhood development.

Registered Nurse Journal asked The Aboriginal Nurses Association of Canada (A.N.A.C.) to share its reaction to the summit's outcome.

The A.N.A.C. supports these recommendations in theory but implores all stakeholders to adopt an engaging approach that is systematic, measurable and concrete. Partnerships and collaboration are key but they must begin with communication that is inclusive and representative of the vast diversity found in the Aboriginal population of Canada. It is imperative that the A.N.A.C., as a national organization representing nurses working in Aboriginal communities, be representative of its membership at decision-making forums to facilitate these collaborations and formation of partnerships. Stakeholders need to engage frontline nurses for solutions.

Recruitment and retention must be the focus. The human resource issues of safe work environment, funding, isolation, jurisdictional confusion and wage parity need to be systematically addressed and challenged with workable solutions in each province and territory. This is critical for successful implementation and sustainability of any health program. **RN**

RNAO members respond to the call

RNAO president Joan Lesmond and executive director Doris Grinspun would like to thank the many RNAO members from across the province who responded quickly to home office requests to contact key politicians during the Health Summit. We offer a special thanks to members from the Ottawa area who showed their support at summit events.

By adding their credible voices to the call for increased, but conditional, health-care funding, RNAO members are making it more difficult for politicians to dodge the pressing need to halt further for-profit health-care services. They are also serving notice that registered nurses will be watching to ensure that the welcome investment in health care gets to where it is needed most: to people waiting for diagnosis, treatment or prescription drugs; to families looking for new and better ways to access more nurses and other health-care providers; and to seniors and others in need of home-care services.

The political impact of individual RNs from constituencies across Ontario urging the premier, prime minister and health minister to act on these imperatives cannot be underestimated. It is only through the collective action of the association that we will secure the policy changes that the profession needs and the public demands and deserves. **RN**

Canadian Labour Congress, featuring health-care activist Shirley Douglas and Serge Lalonde.

- Do a live interview with Report on Business Television on the health summit, emphasizing the importance of not-for-profit health-care delivery and conditionality.
- Attend OPSEU mix and mingle, where members are debriefed on daily events.
- Join in on strategy sessions, late into the night, with nurses and other health-care organizations across country.

Tuesday, Sept. 14

- Join other health-care advocacy groups and unions assembled outside the Conference Centre. With communiqué and paper plates in hand (proclaiming "Put it on the table…Stop Privatization), I speak with New Brunswick Premier Bernard Lord, Manitoba Premier Gary Doer, and Newfoundland Premier Danny Williams about the necessity of raising the for-profit health-care issue.
- Conduct an interview with CBC radio, responding to a report by the Fraser Institute about health-care spending and hospital/nurses' wages.
- Speak with Citytv's Adam Vaughan, who later challenged the P.M. on pharmacare, using what I had told him as an example.
- Consult staff and participate in strategy meetings with coalition groups on how to highlight the need for the federal government to place conditions on the funding and the importance of provincial accountability.
- Approach Peter Mansbridge, anchor of CBC TV's The National, to introduce myself and suggest that the network include more perspectives on health care from nurses. I leave him my card and an open offer to share nurses' knowledge and experience with the nation.

Wednesday, Sept. 15

- Very unfortunate that I have to leave the summit, but I do so with the confidence that RNAO will continue to influence the political and policy making process. I know we may not change the agenda overnight or in any one agreement. But I also know that by consistently and forcefully raising issues on behalf of nurses and the public, we will make inroads in improving the work life of nurses and quality access to health care. **RN**

SINE MACKINNON IS DIRECTOR, COMMUNICATIONS FOR RNAO.

Notice of 2005 AGM

Take notice that an annual general meeting of the Registered Nurses Association of Ontario (herein after referred to as association) will be held at the Hilton Suites, Markham on April 22, 2005, commencing the evening of April 21 for the following purposes:

- To hold such elections as provided for in the bylaws of the association
- To appoint auditors at such remuneration as may be fixed by the Board of Directors and to authorize the Board of Directors to fix such remuneration
- To present and consider the financial statements of the association (including the balance sheet as of October 31, 2004), a statement of income and expenditures of the period ending October 31, 2004, and the report of the auditors of the association thereon) for the fiscal year of the association ended October 31, 2004.
- To consider such further and other business as may properly come before annual and general meetings or any adjournments or adjournments thereof.

By the order of the Board of Directors,

Joan Lesmond, RN, BScN, MSN
President

RNAO Recognition Awards 2004-2005

Call for Nominations

You're an RN for many reasons. Perhaps we can give you one more. The nomination deadline for the following Recognition Awards is November 26, 2004:

- RNAO Leadership Award in Political Action
- RNAO Chapter of the Year Award
- RNAO Interest Group of the Year Award

Honour your colleagues today. Visit www.rnao.org for nomination forms, or contact the RNAO office at info@rnao.org.

RNs resolve to shape nursing and health care

Do you want to change nursing and health care in Ontario? As a member of your professional association, you can put forward resolutions for ratification at RNAO's Annual General Meeting which takes place on Friday, April 22, 2005. By submitting resolutions, you are setting the wheels in motion to give RNAO a mandate to speak on behalf of all its members. It is important to bring forward the many pressing health and social issues that affect nurses' daily lives. RNAO members represent the many facets of nursing within the larger health-care system. You are a key ingredient in ensuring nurses' voices are heard and in pushing for healthy public policy across the province.

RNAO encourages chapters, region without chapters, interest groups and individual members to submit resolutions, for ratification at the 2005 annual general meeting, to David McChesney, executive assistant, by fax at 416-599-1926 or mail to home office.

Please keep in mind:

- the deadline for submission of resolutions is **January 10, 2005** at 5:00 p.m.
- a one-page backgrounder must accompany the resolution
- the resolution must bear the signature of a member of the association
- all resolutions will be reviewed by the Provincial Resolutions Committee

Please refer to the following resolution for guidance:

WHEREAS homelessness is rising throughout Ontario, shelters are overcrowded and many do not meet the standards set by the United Nations, and the per diem rate offered by the Ontario government to municipalities to operate shelters is well below the actual operating cost, AND

WHEREAS the total private rental loss in Ontario from 1996 to 2001 is 45,000 units, existing rental vacancies are at the upper end of the rent scale, and social housing waiting lists are growing in almost every part of the province, AND

WHEREAS the Ontario government cancelled all funding for new affordable housing in 1995 and since then has cut $879.1 million from provincial housing programs, and the shelter allowance portion of social assistance has not been changed since it was cut by 21.6 per cent, AND

WHEREAS housing and homeless advocates such as the Toronto Disaster Relief Committee and the Housing and Homelessness Network in Ontario have called on the Ontario government to increase provincial housing spending to $900 million annually and set a target of at least 15,000 new affordable units annually,

THEREFORE BE IT RESOLVED that RNAO collaborate with the Toronto Disaster Relief Committee and the Housing and Homeless Network in Ontario to lobby the Ontario government to:

- increase the per diem rates to municipalities for homeless shelters to cover the actual cost of operating shelter beds and services,
- increase funding for affordable housing, implementing an interim plan to shelter the increasing numbers of homeless until the promised housing is available, AND
- adopt the recommendation of the coroner's jury at the Kimberley Rogers inquest to increase social assistance to realistic levels.

DEADLINE, JANUARY 10, 2005 AT 5:00 P.M.

by **Jill Shaw**

From classroom to clinician

A glimpse at the evolution of nursing education through four centuries.

ON April 12, 2000, the Government of Ontario announced that a Bachelor of Science in Nursing (BScN) would become the minimum requirement for nurses entering practice in Ontario beginning Jan. 1, 2005. To mark this important step in the evolution of nursing education, we reflect on nursing's progression as a profession from the days of the French Canadian settlers to present-day practice. Nurses' pivotal role in the health of Canadians has never changed, but nursing education has evolved over the centuries to ensure every generation of RNs builds on the tradition of excellent and compassionate patient care.

1600-1899

1639 – Augustine nuns establish a medical mission in Quebec, introducing the first nursing apprenticeship training in North America. Learning took place primarily through observation.

1874 – First formal hospital nurse training program in Canada opens at the General and Marine Hospital in St. Catharines, Ontario.

1900-1939

1919 – First Canadian degree program in nursing begins at UBC.

1920 – The Red Cross begins subsidizing instruction in public-health nursing at universities across Canada. These Red Cross certificate programs later develop into nursing degree programs.

1922 – At the urging of RNAO's predecessor, the Graduate Nursing Association of Ontario (GNAO), Ontario passes a law protecting the title of Registered Nurse from misuse.

1925 – The first minimum curriculum for nursing education is established. GNAO changes its name to RNAO to reflect the recognition of the title Registered Nurse.

1932 – Dr. George Weir, appointed by the Canadian Medical Association and the Canadian Nurses Association to head a committee studying medical education, recommends nursing education operate on a budget separate from the hospital's to meet the educational needs of students rather than the labour needs of the facility.

1933 – The School of Nursing at the University of Toronto is established as an autonomous body within the university, the first school in the country to operate as such.

1940-1959

1942 – University of Toronto is the country's first school to offer a degree program that combines arts and sciences education with a nursing component.

1948-1952 – CNA operates a demonstration nursing school with practical and educational components in association with, but separate from, the Metropolitan Hospital in Windsor. The school is funded by the Red Cross. The program is less than three years.

1959 – First master's degree program in nursing is established at the University of Western Ontario. Two students are enrolled in the first year of the program.

1960-1989

1964 – Supreme Court Justice Emmett Hall's Royal Commission on Health Services recommends nursing programs operate independently of hospitals and prepare nurses in less than three years.

1964 – RNAO leads the founding of the School of Nursing at Ryerson Polytechnic University, the first Canadian diploma nursing program to be offered in an educational institution. The program develops into a two-year course with outstanding results.

1967 – Twenty Community Colleges of Applied Arts and Technology (CAATs) open in Ontario.

1969 – RNAO endorses the baccalaureate degree as entry to practice in Ontario.

1969 – Humber College opens the first nursing program offered by a community college.

1973 – All 56 Ontario hospital nursing schools are now incorporated into CAATs.

1990-2004

1991 – University of Alberta establishes the first Canadian doctoral program in nursing.

1993 – University of Toronto establishes Ontario's first doctoral program in nursing.

1998 – Council of the College of Nurses of Ontario recommends a BScN as the minimum standard for entry to practice.

1999 – Ministry of Health announces the creation of the Nursing Education Initiative (run by RNAO) to assist nurses in continuing their education.

1999 – Ontario's Nursing Task Force recommends the BScN as the minimum requirement for entry into practice in Ontario.

2000 – Government of Ontario announces a baccalaureate degree will be the minimum education required for new RNs beginning Jan. 1, 2005.

2004 – The last class of diploma program nurses graduate. **RN**

Saying goodbye to the diploma program

During the dwindling days of the diploma nursing program at Fanshawe College, my colleagues and I discussed our feelings of sadness that the program was coming to a close. To achieve a peaceful resolution we turned to our students.

In my final class, I invited students to discuss the memorable events of their graduation year. One always remembers what happened that year and marks things in relation to it. I recall the words of Una Ridley, director of the Sarnia General Hospital School of Nursing, in my graduation year, 1969. "This is the year of the first heart transplant, the year a man will walk on the moon, and the year RNAO has endorsed a BScN as qualification to enter practice." She did not mention other things that I remember about 1969, like Woodstock and rallies protesting U.S. involvement in Viet Nam, and she did not know it would take 36 years for the baccalaureate degree to officially become the credential for entry to practice.

I thought my students would mention their status as the final class of a proud educational program, but they surprised me. Instead, they talked about the war in Iraq, SARS, the space shuttle disaster, living with the aftermath of 9/11, and Mike Weir, a Canadian, winning the masters tournament.

They did not mention being the last class of the program because they have no sense of an ending. For these students, it is a beginning. The same exciting, hope-filled, scary, joyous, proud, brave and tentative beginning we all have experienced.

It is nursing.

This notion that things change yet stay the same gives me what I need to process the sadness and loss I feel as we say goodbye to the diploma program. It surely is an ending, but it is not a finish. The workforce and RNAO are full of wonderful diploma RNs.

As we say goodbye to Ontario's diploma programs, we should also say thank you. They made us what we are today and provided a solid foundation to support the future. Every RN in Ontario should join in salute of this wonderful component of nursing education.

With these thoughts I can say a peaceful farewell.

PATRICIA PATTERSON, RN, BScN, MA, CPMHNC, IS A PROFESSOR IN THE UNIVERSITY OF WESTERN ONTARIO-FANSHAWE COLLEGE COLLABORATIVE NURSING PROGRAM, AND IS PAST PRESIDENT OF THE MIDDLESEX/ELGIN CHAPTER OF RNAO.

Illustration: Diane Fenster

by **Anila Sunnak**

Capturing the **CNS** concept

IN June, RNAO's Clinical Nurse Specialist Interest Group (CNSIG) celebrated its 25th anniversary. Clinical Nurse Specialists (CNS) from across the province marked the milestone at an education and networking event held at Toronto's Sunnybrook and Women's College Health Sciences Centre. The keynote address by Dr. Janet Pinelli, a professor, CNS and neonatal practitioner at McMaster University's Faculty of Health Sciences, was entitled "We're all dancing to our own tune: The definitional confusion surrounding advanced nursing practice." Registered Nurse Journal *pursues a similar theme with this profile, sharing the challenges and accomplishments of two CNSs while clearing up misconceptions about their place in the profession.*

"It's a complex and creative nursing job, and best of all I get to work with children and families. I love it," says Jennifer Boyd, a CNS at the Division of Neurology at Toronto's Hospital for Sick Children. In addition to her broad nursing expertise in pediatric neurology, Boyd is an authority on the care of patients with neuromuscular disorders, infantile spasms and multiple sclerosis (MS). She is also part of the Sick Kids team that created the world's first pediatric multiple sclerosis clinic.

Recognized by her peers as an expert, she receives many international requests to speak, publish and consult. She mentors other nurses, develops clinical practice guidelines, facilitates new ways of improving quality of care, presents at national and international conferences, and conducts research in her field.

Like Boyd, CNS Christine Struthers is also charting new pathways in nursing. At the University of Ottawa's Heart Institute, Struthers is part of a health-care team charged with the design and delivery of a groundbreaking cardiac program serving 13 remote Ontario communities. The program delivers virtual checkups to help diagnose and treat patients who can't easily see a health-care provider.

Struthers identifies and assesses technology for the program, and teaches patients how to use the technology from home. She also consults professionals in other Canadian jurisdictions interested in introducing the program.

Illustration: Stéphane Denis/Three in a box

Boyd and Struthers are two impressive examples of CNSs. According to the Canadian Nurses Association (CNA), a CNS is an advanced practice nurse (APN) who holds a master's or doctoral degree in nursing with expertise in a clinical nursing specialty. Another type of APN is an acute care nurse practitioner (ACNP). Nationally, there are only 2,064 CNSs who make up 0.9 per cent of the nursing workforce. In Ontario, 571 nurses assume these roles, or 0.7 per cent.

Armed with advanced education and an inspiring arsenal of clinical and research skills, CNSs take on key leadership and research roles in the field. And perhaps more than any other APN role, CNS practice encompasses a wide spectrum of clinical and theoretical areas. Consequently, these nurses are grounded in the day-to-day, but educated to keep an eye on bigger policy issues and patient care improvements.

While the CNS role varies depending on the priorities of the institution for which they work, three essential responsibilities define the role: to provide leadership, to help integrate research findings into nursing practice, and to work towards change within the health-care system. CNSs improve the quality, safety and cost-effectiveness of patient care, and help nurses move the system toward new and better approaches to care.

The CNS usually works in a team with other health-care professionals in areas such as geriatrics, wound care, cardiology, surgery, pediatrics, mental health, pain management, infectious diseases, palliative care, family health, public health, rehabilitation, and diabetes care. Through their work, they find better, faster and newer ways to provide care. They also work independently on research and education projects.

"We have expert knowledge in the care of specific patient populations that is both up-to-date and evidence-based. We also play an important leadership role in advocating for patients and families to ensure they get the information, services and supports they need," explains Boyd.

The CNS role is often difficult to differentiate from other advanced or expanded nursing roles such as the clinical educator or nurse practitioner (NP). This is partly due to the fact that they share a similar working style, which, according to the Canadian Association of Advanced Practice Nurses (CAAPN), is simultaneously independent and collaborative. These roles, however, have different mandates. A CNS cannot independently diagnose and prescribe medicine or tests like an NP. And an NP often focuses on individual patient and family care rather than on changes to process or practice.

Since CNSs only comprise a small percentage of the nursing workforce, health-care managers are often not familiar with the full capacity or range of skills they offer. CNSs, for instance, can often enhance the practice of frontline staff by being a valuable role model and resource for clinical practice. Confusion around the role, however, can cause inefficiencies, result in duplication of work, and strain professional relationships. "The CNS role is not widely recognized and I am constantly describing and clarifying to others what I do," explains Boyd.

Heather Elliott, chair of CNSIG, sees two other challenges. "Sometimes institutions emphasize only the educational capacity of a CNS, thereby missing out on other key skills in research and leadership…they're spread too thin and unable to make a difference in any one area," she says, adding these institutional blindspots mean our health-care system is losing some very valuable opportunities.

In a 2004 CNSIG membership survey, CNSs indicated a need to define clearer boundaries for the role, which may lead to more understanding and acceptance. They also called for more resources to fulfill their role in health promotion. They believe there is a tendency for the role to evolve into a managerial or administrative job, thereby limiting opportunities for direct contact with patients.

CNSIG's past chair, Nancy Purdy, and current chair, Heather Elliott, both emphasize the need to educate other health-care professionals about the uniquely comprehensive capabilities of a CNS through workplace campaigns targeted at patients, staff nurses, administrators and other nurses. "An increased awareness would hopefully result in the role being used more effectively," says Purdy.

Despite these issues, many CNSs find the autonomy in this high-level nursing position very gratifying. "My role is constantly evolving and I don't have a typical day. My involvement with presenting and publishing has afforded me the opportunity to meet and communicate with nurses from around the world," explains Boyd.

Struthers is equally pleased with the career opportunities she has been given as a CNS. "I love my role…I'm helping to redefine and expand cardiac health care. I couldn't imagine a better job." **RN**

ANILA SUNNAK IS A FREELANCE WRITER IN TORONTO.

The CNS: Five key areas of competency

CLINICAL PRACTICE: providing direct patient care; performing advanced clinical assessments; collaborating with interdisciplinary teams to enhance coordination of care and reduce length of stay; and offering a holistic and theoretical approach to care.

CONSULTATION: consulting patients, families, nurses and other health-care professionals.

EDUCATION: teaching other nurses through formal and informal strategies; teaching patients and families; and establishing educational programs to address specific health and wellness issues.

RESEARCH: displaying advanced skill in the retrieval, review and critique of research to develop evidence-based clinical protocols; and leading research studies or acting as partner/stakeholder in collaborative research.

LEADERSHIP: taking the lead on projects related to clinical issues, quality improvement, and research-based evidence to create changes in practice; developing clinical practice protocols to improve patient outcomes; and implementing systemic changes to enhance standards of care.

Source: RNAO's Clinical Nurse Specialist Interest Group (CNSIG)

by **Kimberley Kearsey**

Forensic nursing struggles out of the shadows

After a decade of discussion, forensic nursing still ill-defined.

The criminal justice and health-care systems recently converged in a very public way when a provincial court judge accused Ontario's forensic health-care professionals of routinely failing to diagnose the mental health of prisoners making their way through the court system.

Behind this accusation lie two profound and chronic problems: poor province-wide coordination of court-ordered psychiatric assessments and too few nurses to accommodate the needs of the population.

But these are not the only challenges troubling the forensic sector. An even bigger challenge is the lack of knowledge and understanding of the size and scope of the forensic field, and the role nurses play in it.

The word "forensic" typically conjures up images of crime scenes and criminal investigations fraught with intrigue and deception, an image reinforced by TV and movies chronicling the exciting lives of forensic professionals in the field. Hollywood's depiction of this complex health science, however, does not realistically reflect what forensics truly entails.

And that's not just because Hollywood tends to make things larger than life. It might also be caused by the fact that few people can clearly define this complex profession, and especially the nursing role in it.

An often misunderstood area of nursing practice, forensic nursing has slowly emerged from the shadows over the past 10 years, sparking national interest and debate about its viability and potential as a nursing specialty. Forensic nursing in Canada is generally considered a sub-specialty of psychiatric nursing while in the U.S., it is officially recognized as a specialty of the profession.

Forensic nursing is an umbrella term referring to nurses whose practice pertains to the law (i.e. sexual assault nurse examiners, people who specialize in violence, legal nurse consultants or nurses working in psychiatric facilities and jails). In a nutshell, any time the criminal justice and health-care systems intersect, you will find a forensic nurse.

According to Cindy Peternelj-Taylor, nursing professor at the University of Saskatchewan and associate editor for the *Journal of Forensic Nursing*, "the nursing role in a forensic setting is often difficult to define because there is no clear conceptualization of what forensic nursing involves."

That ambiguity results in confusion and inconsistency across the country when determining the skills necessary to call oneself a forensic nurse. It also makes it difficult for RNs like Connie Middleton to tell people what they do for a living.

A forensic nurse on a minimum security ward at Hamilton's St. Joseph's Health Centre, Middleton has worked with forensic patients for almost 15 years. She considers herself a forensic nurse, but doesn't identify herself as such when people ask her what she does. "I just say I work in psychiatry on a forensic floor. I don't make it sound as though it's incredibly courageous."

Beverly Roy, a corrections nurse in North Bay for almost 15 years, also views herself as a forensic nurse. "I don't tell people I'm in forensics because a lot of people don't understand what that is," Roy explains. She says most people are shocked or curious, and comment that it must be scary to work in a jail. Others ask how she could possibly work with "people like that."

Her answer is always the same: "I'm a nurse. Nursing is nursing," she says, adding that everyone is entitled to health care regardless of their personal history.

Given the difference between what Middleton does as a forensic nurse in a hospital – assessment, evaluation, one-on-one care – and what Roy does as a forensic nurse in a

Illustration: Anthony Trammaglia/i2i art

Applying for specialty designation

Designating an area of nursing practice a specialty in Canada requires application through the Canadian Nurses Association (CNA), and often entails a rigorous approvals process followed by the development of a certification examination.

According to Janet Mann, manager of CNA's certification program, the process begins when a group identifies itself as unique, and meets specific criteria for consideration. Among the criteria: national standards of practice; research indicating the role is unique; at least 60 nurses willing to commit to supporting a certification exam; and a national organization/body representing the interests of the group. If no organization or national body exists, the group can apply through a steering committee comprised of seven to eight representatives from across the country.

Mann says CNA has not been approached by forensic nurses.

There are 14 nursing specialties for which certification is currently available through CNA: cardiovascular; critical care; critical care, pediatric; emergency; gastroenterology; gerontology; hospice and palliative care; nephrology; neuroscience; occupational health; oncology; perinatal; perioperative; and psychiatric mental health.

prison – health promotion, disease prevention, primary care – it is not surprising that nursing practice in forensic settings is not uniform.

Donald Rose, an RN and PhD candidate in the Faculty of Nursing at the University of Toronto, says the definition of forensic nurse and forensic psychiatric nurse varies depending on who you talk to. Amid these varying opinions, however, emerges a consensus view: much work must be done to clearly define the role, and to help the public and the profession recognize the skills and characteristics forensic nurses require—skills that some say are sufficiently exclusive to warrant serious consideration as a specialty.

Rose, who is conducting a research project on the ethical tensions in the practice of forensic and forensic psychiatric nursing, says people in Canada describe the field very differently from people in other parts of the world, particularly the U.S.

In fact, comparing forensic nursing in Canada with forensic nursing in the U.S. is like comparing apples to oranges, according to some. "You really can't compare because it's so different on so many different levels," Angela McNabb, advanced practice nurse in the Law and Mental Health Program (LMHP) at Toronto's Centre for Addiction and Mental Health (CAMH), says.

Forensic nursing is a specialty in the U.S., and RNs can pursue masters or PhD level education in the field. They require a different set of skills and characteristics from Canadian nurses in the field. For instance, forensic nurses in the U.S. can be called upon to present evidence at a crim-

inal trial. They are key players in the investigation of murder and the preservation of evidence. In fact, the role of death investigator or nurse coroner is a viable career option across the border because coroners don't have to have a medical background. Forensic nurses need to take the lead in offering the health-care perspective in these cases. That is neither an option nor a necessity for forensic nurses in Canada.

Recognition of forensic nursing as a specialty here at home is something nurses like Middleton and Roy would like to see. RN Sheila McDonald, who did her masters in forensic nursing in the U.S. and is now Provincial Coordinator for Sexual Assault Treatment Centres in Ontario, doesn't necessarily agree.

"Part of me questions if it's necessary to go that route," McDonald says. "My work is with survivors of sexual assault and domestic violence. It's what I do as a nurse that's going to make the most difference...The forensic part of it, while I think good evidence collection and documentation (is key)…it's still what I do as a nurse that makes the biggest difference. There's been a big emphasis on the idea of forensics…it's taken away a little bit from nursing."

McDonald also worries that designating forensic nursing a specialty and developing certification exams may result in fewer and fewer frontline nurses feeling they have the skills to care for those patients who are in trouble with the law or those who are victims of crime. "What would it mean to have this certification? Does it mean that if I have it, I'm better than a frontline nurse working in emerg somewhere who is also going to see a survivor (of violence or crime)?" she asks, adding it's more important to ensure we have people to look after that woman who's been assaulted by her partner, rather than people who think they're not qualified enough to do it.

Peternelj-Taylor, a respected authority on the subject, also ponders the necessity of specialization in this field.

"I could probably argue both sides," Peternelj-Taylor admits. "The job has always been there, but I think the term forensic is newer in our vocabulary. I think more time and perhaps more research to say 'yes this is a distinct area of practice' would help. I think it's a specialty in development."

As with any healthy debate, there are two schools of thought on the issue. McDonald argues one side while others suggest a specialty could facilitate further development of a knowledge base, accelerate the development of assessment and intervention skills, encourage research in the area and promote a sense of identity for nurses working in this marginalized domain or practice.

In its annual collection of statistical information from nurses across the province, the College of Nurse of Ontario (CNO) does not offer a customized check-box for "forensic nursing" when it asks RNs to identify their line of work. Few in numbers, forensic nurses (at least those who choose to refer to themselves as such) are described as reticent to come forward because the title is still so young and easily challenged. Some might not want to overestimate themselves and others may feel a lack of confidence that comes from the public perception that forensic nursing is much more than it is.

In 1993, Peternelj-Taylor recalls an invitation from a group of forensic nursing researchers to all forensic nurses to "come out of the closet" and educate the public and the profession about the work they do. Some have taken up the challenge but a more concerted effort to spearhead advancements in education, research and clinical practice in this field is necessary. That's why Peternelj-Taylor has become so involved in the planning of the fifth biennial *Custody and Caring* conference, an international event in Saskatchewan that focuses on the role of the nurse in the criminal justice system.

"If you want to do something about establishing forensic nursing as a specialty, you have to be all encompassing. It's not just about my work or his work. It's about incorporating all of it," McDonald believes. "One field (or group) is not going to own the concept."

Rose believes the existence of only limited literature addressing the issues and challenges of forensic nursing shows this field is "ripe and ready for a lot of research." When he began looking into literature on the subject in the mid-90s he felt overwhelmed because no one was really talking about it. Almost 10 years later, he's not as worried about silence scaring nursing researchers away.

"It's rewarding in a lot of ways, there are a lot of new things to do, and there's a tremendous amount of research that's just waiting to happen in this area," Middleton notes. "Anyone interested in research could really get their feet wet and move forward in this area."

With plans for the 2005 *Custody and Caring* conference currently underway, perhaps some brain "storms" are brewing and we can look forward to some of those feet getting wet when as many as 200 health-care professionals gather next September to share ideas and generate more attention for this fledgling field of nursing practice. **RN**

KIMBERLEY KEARSEY IS ACTING MANAGING EDITOR.

Did you know?

- In nursing literature, the term forensic was generally accepted in the mid 1980s with its common use as an exploratory term denoting those who work with offenders suffering from mental illness and residing in secure psychiatric facilities.
- Forensic services in Canada target individuals unfit to stand trial, not criminally responsible on account of a mental disorder, guilty by reason of insanity, or subject to a court-ordered remand for a psychiatric assessment under the Criminal Code of Canada.
- Forensic patients can be perpetrators of serious offences including arson, murder, sexual assault and child abuse, or minor offences such as petty theft.
- The Ontario Review Board (ORB), created in 1992, is mandated to have jurisdiction over mentally ill persons in conflict with the law and is required to review cases and make decisions on the status of these persons annually.
- The ORB can make one of the following three decisions regarding forensic patients: i) detained in custody in a hospital; ii) discharged subject to conditions in which the person would continue to appear before annual review boards; and iii) discharged absolutely where the review board is satisfied that the person no longer poses a significant threat to the safety of the public.

Source: *Rose, D.N. (2004), An exploration of the Concept of Respect in Forensic Psychiatric Nursing, unpublished doctoral proposal, University of Toronto, Canada*

INNOVATIVE PROGRAMS, INITIATIVES DEFINE 2004 MEMBERSHIP YEAR

As we embark on a new membership year, we review a sample of successful, member-driven recruitment and retention programs instrumental in boosting membership participation over the past year.

RNAO welcomes Humber College students

On August 31, Humber College Institute of Technology and Advanced Learning became the first nursing school in Ontario to fully subsidize all of its full-time BScN nursing students' memberships at RNAO. By taking on the membership fees for more than 700 students, Humber has helped to boost student membership to more than 2,200.

"Humber has set an important precedent today," said executive director Doris Grinspun. "It is our hope that other institutions will follow its lead and help students acquire the professional skills and development they need in the future. Ontario will lose nearly 10,000 nurses to retirement or death by 2006; there has never been a more urgent time to develop our future leaders to ensure high quality patient care."

"Nurses play an extremely important role in our health-care system, and we need to ensure they have their professional association's support to excel under sometimes strenuous circumstances," said Dr. Robert Gordon, president of Humber College Institute of Technology and Advanced Learning. "Humber applauds RNAO's efforts to secure full-time employment for new graduates, and recognizes the importance a strong membership base plays in achieving that goal."

RNAO membership automatically guarantees students membership in the Nursing Students of Ontario (NSO), a student-led RNAO interest group that advocates for health and nursing through political action, professionalism and research.

"This is a fantastic initiative for NSO and Humber students," said NSO president Michael Garreau. "We look forward to working with our new members to ensure their voices are heard."

Students can join RNAO for just $20. Membership brings access to political influence, career fairs, career counseling, professional development, the award winning *Registered Nurse Journal*, and RNAO's complete collection of best practice guidelines on CD.

"I am pleased to welcome these students to the RNAO family," said RNAO president Joan Lesmond. "Membership in RNAO and NSO signals to fellow students, faculty and future employers that students are committed to their profession." **RN**

Celebrating 40 years of membership

Thirteen RNs mark 40 years as RNAO members at the start of the 2005 membership year. RNAO thanks each for their support and trust over the years.

- Anne Bender, Mississauga
- Maralene Bergman, Strathroy
- M. Louise Day, Verona
- Susan Dunbar, London
- Helen Hanak, Blenheim
- Barbara Harris, Toronto
- Sandra Keates, Mississauga
- Patricia Kirkby, London
- Ruth Littleton, Lindsay
- Penny Susanne Peters, Kent Bridge
- Larry Stewart, Paris
- Anne Marie Webster, Waterloo
- Barbara Wilson-Meyers, Stouffville

UHN launches innovative recruitment and retention initiatives

Toronto's University Health Network (UHN), comprised of Toronto General Hospital, Toronto Western Hospital and Princess Margaret Hospital, is taking RNAO membership recruitment and retention very seriously as it launches three initiatives to encourage its 2,900 nurses to sign up with their professional association.

As one of the newest members of RNAO's Centre for Professional Nursing Excellence, UHN has scheduled a series of specialized presentations to be held at its three sites throughout the coming year. Led by RNAO Centre staff, these sessions are designed to highlight to staff nurses the attributes of being a professional, including the importance of self determination, a defined body of knowledge, and membership in your professional association.

UHN has also been working with its payroll department to arrange for nurses' membership fees to be deducted directly from their paycheques, an option that will be promoted through pay stubs this fall. At least 100 RNs have signed up for the service, and UHN is hoping the convenience will attract more existing and new members.

As one of the Best Practice Guidelines Spotlight Organizations, UHN recognizes its responsibility to promote membership at RNAO, and has decided that one way to do that is to include "RNAO membership preferred" notices on all of its internal job postings. Preference for applicants with RNAO membership has appeared on postings for senior leadership positions for at least the past three years, but will now appear on all job postings within UHN's three sites. **RN**

ACROSS ONTARIO, MORE AND MORE HEALTH-CARE ORGANIZATIONS ARE SPONSORING RNAO MEMBERSHIPS TO ATTRACT, AND KEEP, THE BEST NURSES IN THE PROVINCE

New perks with a 2005 membership

Nurses renewing their RNAO membership in 2005 are in for a few extra perks this year. A new plastic wallet-sized membership card is now available, along with an RN pin for each new or renewing member. New student members will also receive a free CD of RNAO's Best Practice Guidelines (the CD will be available for purchase at a cost of $15 for regular members).

Employers sponsor RNAO memberships

Across Ontario, more and more health-care organizations are sponsoring RNAO memberships to attract, and keep, the best nurses in the province. In August, Bayshore HealthCare became one of the newest organizations to offer the program, paying 25 per cent of RNAO membership fees for nurses at its Ottawa branch.

Wendy Alexander, Bayshore's area director for Ottawa, says they decided to sponsor memberships after existing RN staff said it would attract employees.

"We want Bayshore to be the employer of choice," Alexander says. Sixteen new RNs are currently enrolled in the program, and Alexander says existing employees can also have memberships sponsored.

Several other employers are also helping nurses benefit from membership, including: Bloorview MacMillan Children's Centre; Fenelon Court (Central Park Lodges); Gardien Health Care Services; Regency Care; Royal Crest; Seiden Health Management; WSIB; Med Emerg; and Saint Elizabeth Health Care.

Nancy Lefebre, vice-president knowledge and practice at Saint Elizabeth Health Care, says her organization has sponsored the entire membership fee for 25 per cent of its RNs for the last three years.

"RNAO members enrich the organization's overall knowledge," she says.

Cori Dmitriew is one of those nurses. A clinical resource nurse at Saint Elizabeth in Thunder Bay, she first joined RNAO in 1999 as a student, and was eager to participate in Saint Elizabeth's sponsorship program when she joined the staff there two years ago. Dmitriew says RNAO's best practice guidelines and professional development opportunities allow her to excel as an RN, and RNAO gives her a voice with decision-makers.

"I really appreciate the political advocacy RNAO does on behalf of nursing," she says. **RN**

Interest groups pay half of membership costs for students

Between 2002 and 2004, almost 1,200 student members at RNAO had their $20 membership fee fully sponsored by interest groups.

Fifteen interest groups have signed on to the sponsorship program in 2005 – but this time with a twist. Rather than sponsor the full $20 for an estimated 830 students, interest groups will pay only $10 per student.

The reason: to give students ownership of their membership.

Eight of this year's 15 participating sponsors have opted to personally select the 360 students they will subsidize. The remaining 470 students will be selected by individual chapters, each receiving gift certificates valued at $10. The number of gift certificates per chapter depends on the chapter size. The gift certificates are courtesy of the seven remaining sponsors that have signed on for the 2005 membership year.

For more information, call Daniel Lau, Director of Membership, 1-800-268-7199/ 416-599-1925 ext. 218. **RN**

Calendar

Date	Event	Details
November 4-5	**Geronotological Nurses Association Annual General Meeting and Conference**	Holiday Inn, Point Edward, Ontario
November 6	**Parish Nursing: Reality Check**	St. George's Catholic Church Hall 1164 Commissioners Road West, London
November 12-13	**National Nurse Practitioner Conference**	Marriott Eaton Centre, Toronto
November 17-18	**4th Annual International Healthy Workplaces in Action Conference**	Hilton Toronto Suites, Markham
November 25	**Working Effectively in Organizations** Regional Workshop	Metro Hall, Toronto
November 28 - December 3	**Nursing Policy Institute 2004**	Nottawasaga Inn, Alliston, Ont.
December 3	**International Nurses Interest Group** Biannual Conference	Crown Plaza Hotel, Toronto

Unless otherwise noted, please contact Vanessa Mooney at the RNAO Centre for Professional Nursing Excellence at vmooney@rnao.org or 416-599-1925/ 1-800-268-7199, ext. 227 for further information.

CLASSIFIEDS

continued on next page

research. He outlines specific cognitive behavioral treatment protocols to address problems for which patients most commonly seek help, including acute and chronic depression, anxiety disorders, personality disorders, relationship problems, anger issues, alcohol and drug abuse, and eating disorders. For a complete brochure, phone 1-800-456-5424 or visit www.jackhirose.com

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- *Power of the therapeutic relationship in nursing*

Key Note Speaker

Diann B. Uustal RN, BS, Ed. D is an internationally known consultant, educator and clinical ethicist. This dynamic woman is the author of Clinical Ethics and Values: Issues and insights in a challenging health care environment and Caring for Yourself – Caring for others: the ultimate balance.

Early Bird Registration: $150 per person (on or before January 31st 2005)
Registration: $175 per person, $75 per student
Day include soon tinental breakfast, luncheon and refreshments.

For more details on the conference and abstract submission, please email us at: PEN2005@cvh.on.ca or call 905-813-2100 ext. 5949.

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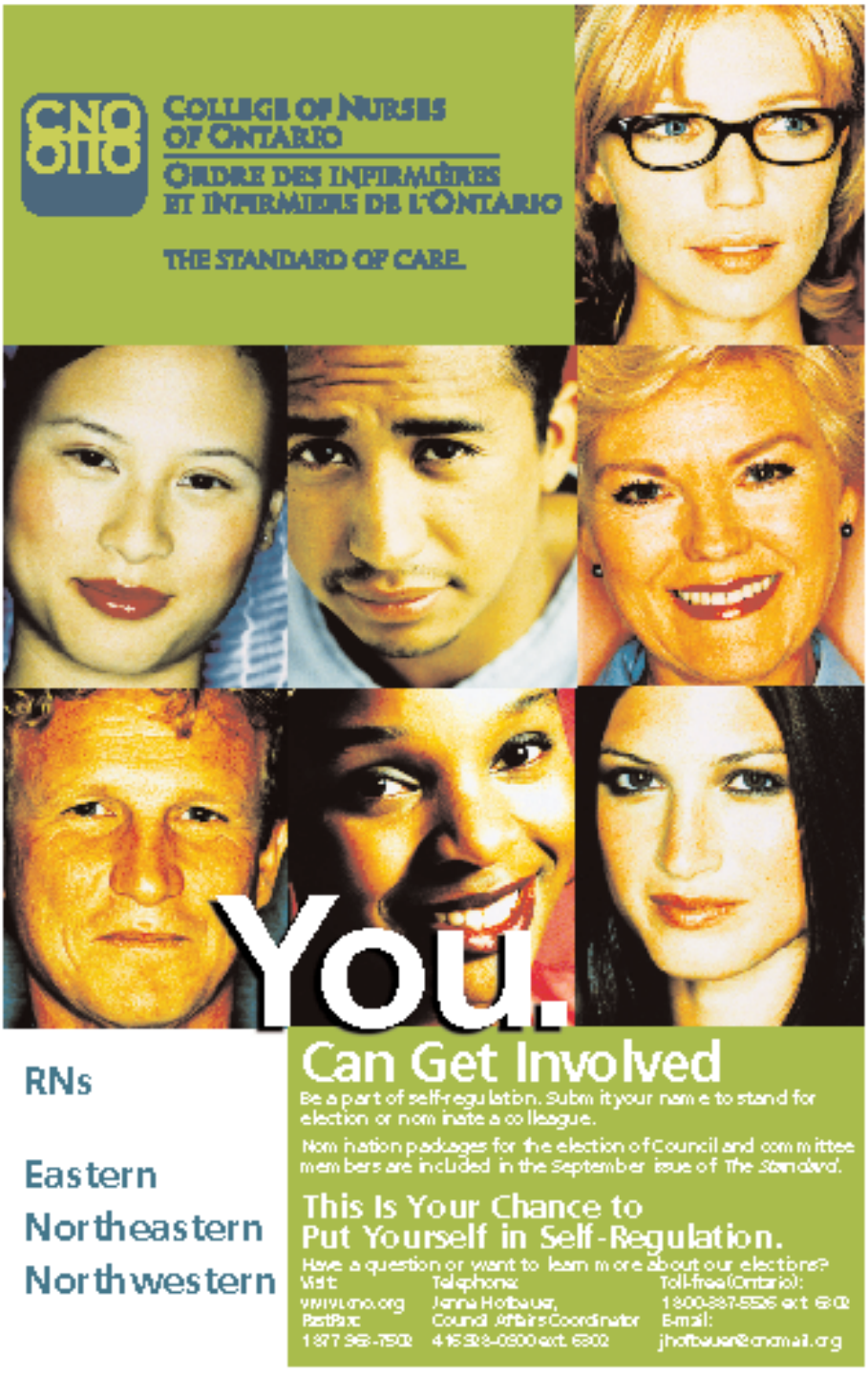
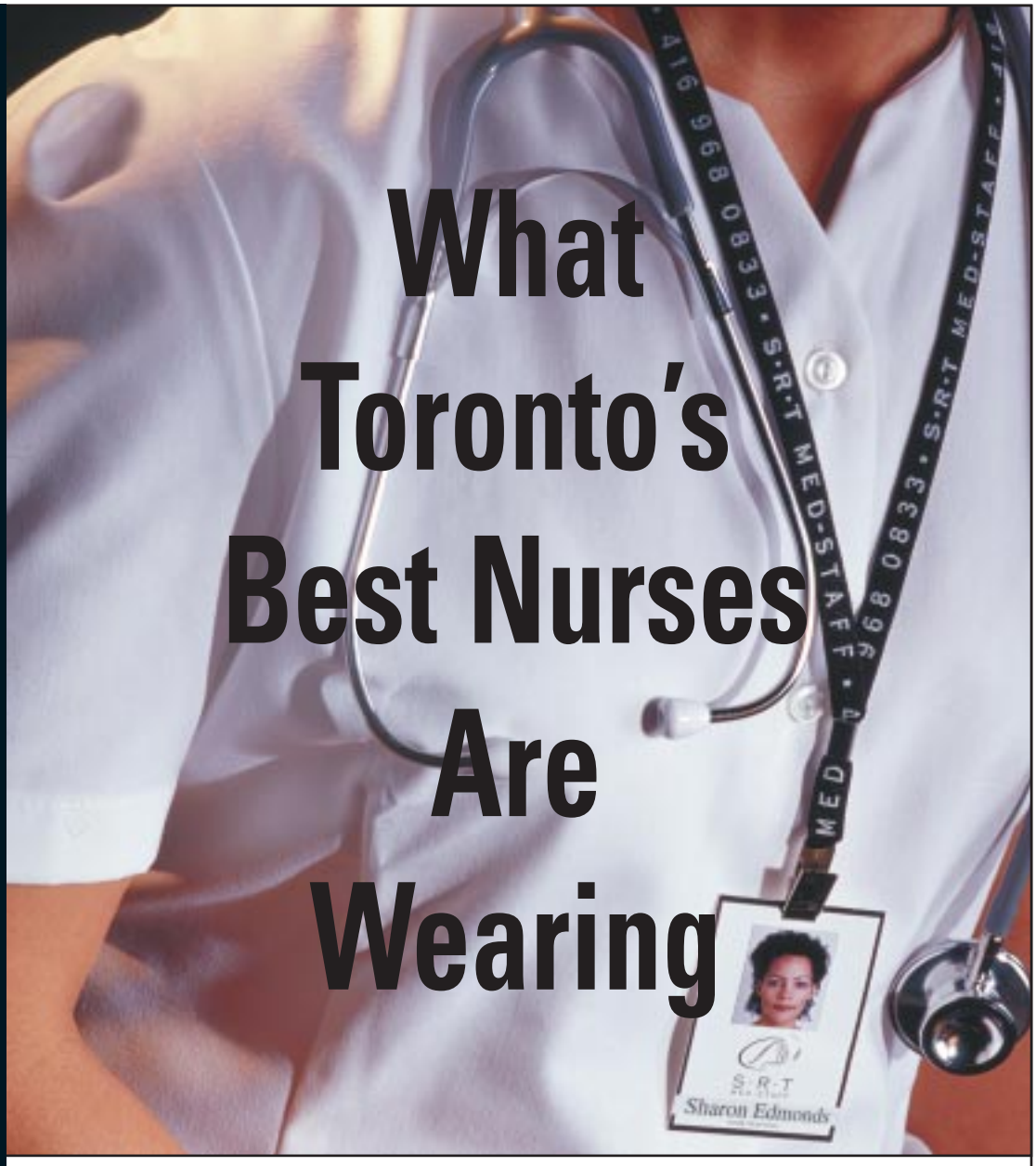


NURSING EDUCATION INITIATIVE

A new funding cycle has been approved by the MOHLTC! For pertinent deadline information or to obtain a copy of the application form please **visit the RNAO Web site at (www.rnao.org)**.

For the most current information about the Nursing Education Initiative please contact:

RNAO's Frequently Asked Questions line **1-866-464-4405**
OR
e-mail Meagan Wright and Iris McCormack at **educationfunding@rnao.org**.



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