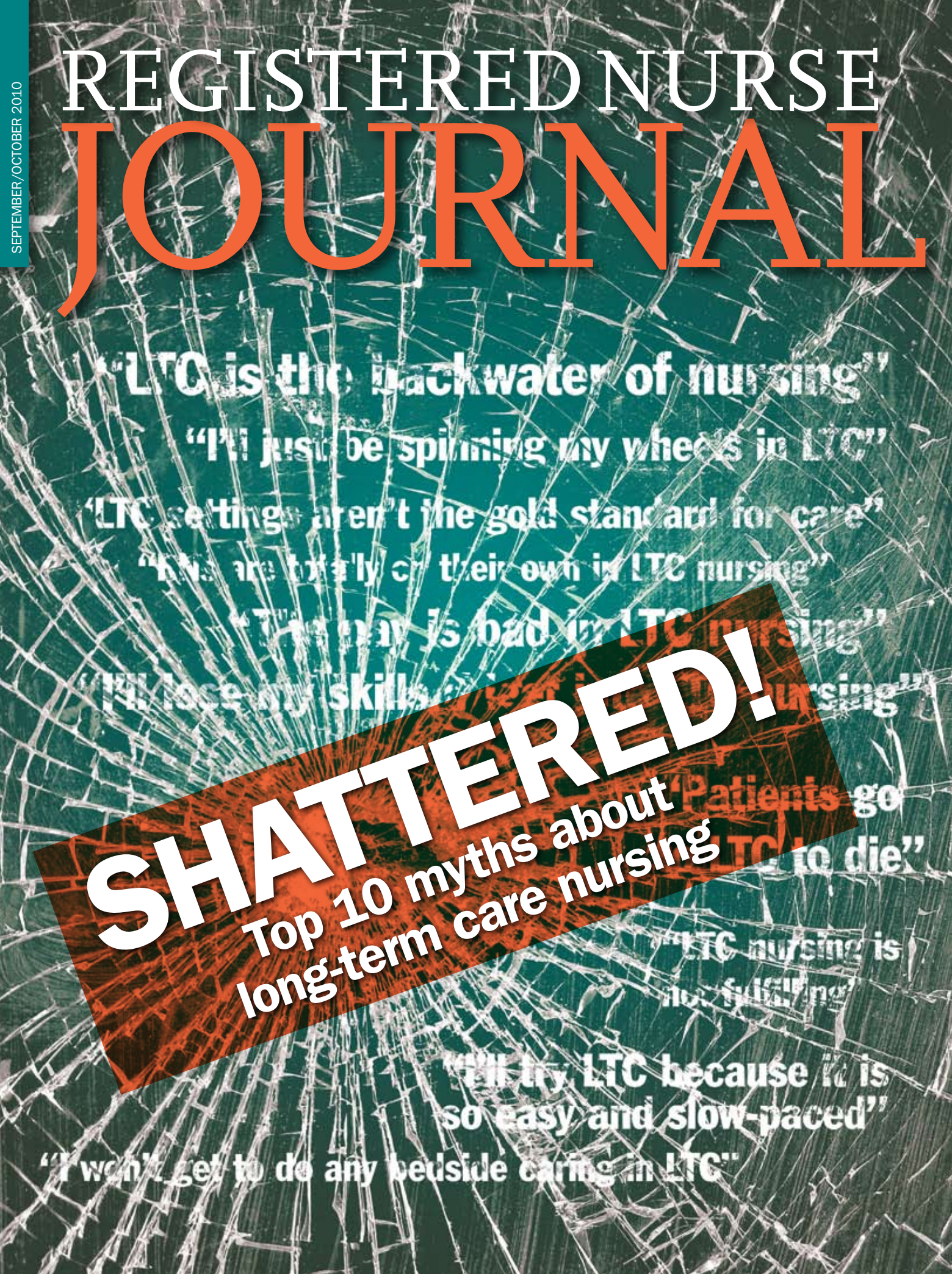
SEPTEMBER/OCTOBER 2010

REGISTERED NURSE JOURNAL



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VOL. 22, NO. 5, SEPTEMBER/OCTOBER 2010

REGISTERED NURSE JOURNAL

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85 years

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EDITOR'S NOTE KIMBERLEY KEARSEY

A matter of perspective

I've stayed overnight in hospital only twice in my life: when I was six and having my tonsils removed; and more than three decades later when I gave birth to my son. I can't recall much from my first experience, except that I got popsicles and a doll that didn't leave my side. My second, however, is fresh in my mind since it happened 15 months ago.

Having a baby is hectic, overwhelming, emotional, and a little awkward with the crowd of people peering into your privates. It's remarkable the difference a team of capable, efficient and empathetic health-care professionals can make in the cloud of chaos.

It took 14 hours to deliver my son Sebastian. I started labour at one hospital and ended up at another. My experience at each would make a nice case study on contrasts.

Reading the personal accounts of nurses as patients (pg. 12) really resonated with me, and was a fitting feature to work on straight off my maternity leave. I think anyone who's accessed the health-care system for themselves or a loved one will find these stories intriguing, and will learn just as much about their own practice as the nurses who tell them did about theirs. I hope you enjoy reading them. **RN**

NURSES MOURN DEATH OF COLLEAGUE

RNAO would like to extend sincere condolences to the family and friends of Sonia Varaschin. Remains of the 42-year-old registered nurse and RNAO member were positively identified Sept. 7, a week after she disappeared from her Orangeville home. The OPP say their investigation into her murder continues.

RNAO Executive Director Doris Grinspun recently visited the family on behalf of the association and Ontario nurses. Sonia loved working with children, her mother told Grinspun. While working at the Hospital for Sick Children and at Southlake Regional Health Centre, she was always there for the kids and the parents, her mother remembers. "Sonia was a strong advocate for both," she said, adding that her daughter was also passionate about skiing and volunteered as a ski instructor for the visually impaired.

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Power in association

Recently I had the opportunity to meet with representatives of the nursing student association with our executive director. I was so impressed by their vision, their values, commitment to social justice, and their eagerness to put in their own time and energy to improve the health-care system and their chosen profession.

We talked about the power of *association*. By definition, association means…"an organization of people with a common purpose and having a formal structure." It's a fairly simple and straightforward description. However, in my view, understates a critical dimension that is the power of *association*. Association membership is a commitment that allows each of us to accomplish in a group what we could not do alone. It allows us to pursue our individual passions or support others in the pursuit of their stated goals. In the case of RNAO, this occurs at the chapter, regional or interest group level.

Whether that passion is simply to be a member or to participate more actively in initiatives aimed at improving the health status of a population, developing or implementing a best practice, improving the status of our profession or supporting those who wish to take on a leadership role, the opportunities to be involved are limitless. *Association* is critical in an organized, democratic society and it is a right that we need to exercise in the pursuit of good. RNAO is an example of a model association.

At any particular time in our careers we are personally and professionally at different places. We all bring to our profession and the association a different focus, levels of knowledge, education and skill. We all have something important to contribute whether we are just starting out or nearing the end of our career. It is this diversity which provides richness and contributes to thoughtful debate and coherent policy direction and decision-making.

> "We all have something important to contribute whether we are just starting out or nearing the end of our career."

For each of us, our personal circumstances dictate how much time and energy and effort we are able to contribute. The power of *association* is that we can all contribute to RNAO.

There are many challenges and changes in the health-care system today: an aging population, increased workloads, changing nursing care delivery models, changing social structures and political ideologies. We can have an impact. However, as an association, we have shown that there is power in the collective to influence change and to provide support to each other and strengthen our individual message and voices.

At the most recent Canadian Nurses Association meeting there was a concerning undercurrent that crossed several forums around changes in nursing care delivery models, staff mix, and the voice of nursing on these issues. As I listened to the discussion, I was impressed with the diversity of perspectives from front-line providers, labour, administration, education and research. The depth of knowledge, genuine concern and engagement was palpable. While the issues were concerning, I left feeling reassured that there was consensus on the goal to organize and work together in a way that will benefit patients, the system and the nursing profession. For me, this is the power of nursing.

During this period of significant transition at the national level, there will be those who speak out on the important issues related to health-care funding, delivery, the environment, poverty, and staffing. Some will be asked to carry the message and others (because of personal preference, their employment or other roles) will stay silent to respect the policies of the organizations and systems in which they work.

As we approach another membership year, we have set an aggressive yet achievable target of 33,000 members. I believe adding power and voice is critical as the health-care system wrestles with the significant challenges I've mentioned. In less than a year there will also be provincial and federal elections. We need to work together to shape our political landscape to ensure that the gains we've made on social and environmental determinants of health, and in our profession, are strengthened and given attention throughout the campaigns.

On behalf of the board, I want to thank you for your commitment to RNAO and ask that you renew early and encourage others to join. If each one of us recruits one more member, imagine what a powerful voice 60,000 nurses would have. Now, that's power. **RN**

DAVID MCNEIL, RN, BScN, MHA, CHE IS PRESIDENT OF RNAO.

GET INVOLVED
Visit www.rnao.org for more on volunteer opportunities.

The social construction of caring: An inside look at nurses' work

I WOULD LIKE TO EXTEND A heartfelt thank you for your many congratulatory messages on completing my PhD. You are my inspiration.

As promised, this column focuses on my research. It looks at the everyday practices of registered nurses and exposes the opportunities, challenges and contradictions they encounter in their work. Over a six-month period, I engaged with 24 staff nurses who volunteered to share their lives with me. I conducted 32 one-hour interviews and 408 hours of participatory observation during all shifts and days of the week, on four different units within the same hospital. I wanted to learn: What is the social construction of caring in the day-to-day work of nurses in a tertiary care hospital in Ontario? To answer this complex question I needed to capture: how nurses speak about and practice caring with patients; how nurses engage with others to carry out caring work; and how organizational structures and managerial practices shape (and are shaped by) nurses' caring work.

Three major themes emerged from my findings:

Caring is thinking, doing and being: This first theme touches on how nurses practice caring work in real life. It highlights the disconnect between the way nurses speak about caring during one-on-one interviews and their actual practice as observed in the workplace. When talking, nurses focus mostly on relational activities (listening, being present). By contrast, their practice is heavily anchored in cognitive caring (thinking), followed by physical caring (doing), and relational caring (being). Many aspects of this theme are intriguing. For example, participants rarely mention clinical knowledge and work as a part of caring, even though they repeatedly demonstrate rich clinical expertise in their actions. Nurses describe relational caring as occurring in isolation of cognitive or physical practices. However, in their daily work, relational caring occurs mostly in conjunction with cognitive and/or physical caring. I refer to the three pillars of caring – cognitive, physical and relational – as the nurses' "comprehensive caring work."

> "MY RESEARCH EXPOSES THE OPPORTUNITIES, CHALLENGES AND CONTRADICTIONS NURSES ENCOUNTER IN THEIR WORK."

Managing relationships and silencing knowledge: This theme addresses the tacit and explicit rules that shape nurses' relationships and their ability to express knowledge. Strong power differentials tied to gender, ethnicity, seniority, education and class play an important role in shaping nurses' relationships among themselves and with other health professionals. Nowhere is this power imbalance more acute than in the nurse-physician relationship. During my research, nurses spoke at length about managing their relationships with physicians, especially when they were advocating for their patients. I observed a nurse justifying three times to a physician why a patient, who wanted to have a catheter pulled out, was ready for it. I also witnessed one patient praising the physician for his expertise in pain management, even though it was the nurse who assessed and reported the need for a higher dose of pain killer. Central to this challenge is the interplay between work environment and nurses' voices. For too long healthcare organizations have perpetuated hierarchy to the detriment of genuine teamwork, which includes joint clinical decision making.

Shaping and being shaped by structures and practices: This third and final theme looks at the workplace environment and how it influences nurses' caring work. Nurses in my study see their work environment as both a facilitator and barrier to caring practice. They describe employment status, nursing models of care delivery, skill mix, and time as having the most impact on their caring practices. It is noteworthy that the physical condition of a workplace is seldom mentioned. Instead, organizational structures significantly influence nurses' day-to-day practice. Management practices that focus on full-time employment, nursing care delivery models that advance care and caregiver continuity, the application of skill mix based on patient acuity and complexity, as well as support for uninterrupted time with patients are identified by staff nurses as practices that optimize comprehensive caring work. They also advance positive relationships among nurses, and between them and other team members, especially physicians.

There are important policy implications emanating from my research and on this I will ask your indulgence in my next column. Meanwhile, should you want to view the entire study, visit tinyurl.com/3xcvlqy. And, of course, it goes without saying that any and all feedback is most welcome. **RN**

DORIS GRINSPUN, RN, MSN, PhD, O.ONT. IS EXECUTIVE DIRECTOR AT RNAO

MAILBAG

RNAO WANTS TO HEAR YOUR COMMENTS, OPINIONS, SUGGESTIONS
WRITE TO EDITOR@RNAO.ORG

RNs in years past played a role in helping impoverished parents

Re: Grassroots nursing for impoverished parents, July/August 2010

I do not believe any program designed and implemented by tax dollars should only target one specific socio-economic group, particularly one so difficult to define. Throughout the war years, many midwives conducted programs delivering babies and providing care and teaching for both mother and newborn. When I was in training in the 1950s, our instructor for maternal and child care had a certificate for midwifery and had delivered babies and did pre and post natal infant and child care amongst other duties in the Australian Outback. When I started the public health nursing program in 1960 with the City of Toronto we were involved in pre and post natal programs, which included pre and post natal visits and health teaching as well as child health clinics. My area was inner city, which included working poor, and the majority of my clients were single mothers on welfare. To say this program is a first is questionable. I know I got over 100 mothers back to school and off welfare, and over 100 who admitted to prostitution back to school, then work.

L. Gail Wright, RN
Toronto

Perianesthesia nursing edges closer to formal certification

Re: Taking great pains, July/August 2010

What a great story about how one dedicated nurse is carving a new role for nurse practitioners in anesthesia care. I am president of the Ontario PeriAnesthesia Nurses Association (OPANA). On June 15, the National Association of PeriAnesthesia Nurses of Canada was successful in submitting a proposal for certification to the Canadian Nurses Association. We are now one step away from beginning the process for certification in perianesthesia nursing. *Voice of a Thousand*, a national awareness campaign, generated 1,141 signatures of support from nurses across the country. Members of our own OPANA Board have joined the list of 44 volunteers recruited for certification committees. This fall in Ottawa, we will begin the process of item writing in the development of the certification exams. It is OPANA's goal to support the NP role in anesthesia. This story shows we are moving in a new direction.

Marianne Kampf, RN
Hamilton

RNs to be commended for dedication, passion

Re: Registered Nurse Journal, July/August 2010

It was with pride and delight that I read this issue of Registered Nurse Journal. I became a registered nurse in 1970 and have always been proud to be an RN. My pride was heightened after reading this issue. The featured nurses are to be commended for their dedication and passion. The expanded roles and variety of roles for RNs were well portrayed. As a nursing professor for 35 years, I was involved in writing curriculum for both the nursing and practical nursing programs at a community college. In each revision, the knowledge base and standards were expanded. The expectation for sound critical thinking, evidence-based practice, and independent decision making in the practice setting were broadened. The stories in this issue serve to reiterate why I became an RN. Retired from my teaching career, my hope for the nursing profession remains high.

Margie Warren, RN
Waterloo

A picture says a thousand words

Re: Grassroots nursing for impoverished parents, July/August 2010

What a wonderful way to acknowledge and recognize registered nurses, by having them appear on the cover of the *Journal*. I love it! What a great way to profile the profession.

Lynda Monik, RN
Windsor

NP program helps seniors age gracefully at home

Re: Long-term care "failing" in Ontario, Nursing in the News, July/August 2010

We would like to comment on a positive advancement in long-term care: the Mississauga Halton LHIN/Credit Valley Hospital Nurse Practitioners-Supporting Teams-Averting Transfers (NPSTAT) program. Consisting of NPs working in tandem with attending physicians and staff in long-term care homes, we provide timely acute, episodic care to seniors to avert unnecessary transfers to hospitals. Between July 2009 and April 2010 our work resulted in an 88-92 per cent aversion of transfer rate to hospital. NPSTAT has built meaningful relationships with community partners including the CCAC, five local hospitals, many community programs, health-care teams in long-term care homes, residents, and their families to ensure care in the comfort of one's own long-term care home.

As Doris Grinspun notes, "....we need to help seniors age gracefully at home..." and NPSTAT is making headway to do just that.

Lori Brown, NP and
Heather McGillis, RN
Mississauga, Ontario

NURSING IN TH

A portrait of nurses at work

Nurses at Trillium Health Centre in Mississauga are feeling like local celebrities these days thanks to the efforts of the Mississauga Camera Club and RNAO member **Cathy Dibert**. In September, Dibert, Trillium's Director of Nursing, granted 14 members of the camera club special access to the hospital to take photos and document the day-to-day lives of nurses.

The snapshots are now on display at Mississauga's Living Arts Centre as part of a photo exhibit called *Nurses at Work*. Since Sept. 9, the public has had access to nearly 50 black-and-white photos that capture the joy, dedication, confidence and humility of nurses. The photos were taken on several units, including internal medicine, intensive care, oncology, continuing care, orthopedic and cardiac surgery.

Camera club members approached the hospital about the project because they wanted to bring awareness to the tremendous work of nurses. The exhibit runs until Nov. 7. The club plans to donate a selection of the photos to Trillium to be permanently installed on the walls of the hospital (*Mississauga News*, Aug. 27).

PHOTO: HILARIE McNEIL

RNAO member Julianna Santos (right) shares a moment with RN colleague Jurist Rosales-Tran in the cardiac surgery ICU.

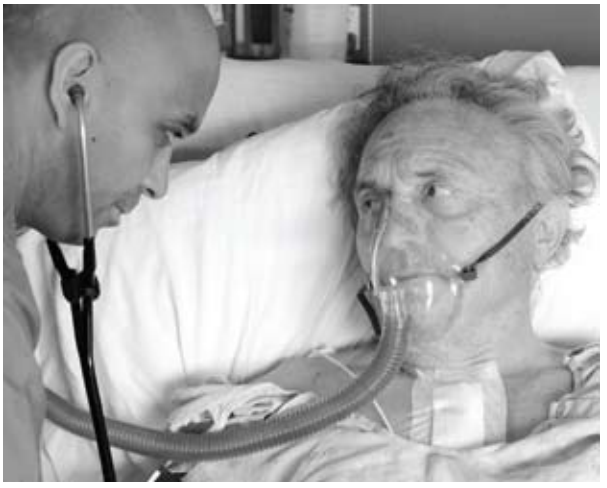


PHOTO: MARCUS MILLER

RNAO member Glenn Ayala comforts a patient in the cardiac surgery patient unit.

Information exchange

RNAO members **Deb Wilson** and **Linda Morrow** supervised exciting advances in information sharing at their respective hospitals this past summer. They joined the growing number of Ontario health facilities using Diagnostic Imaging Repository Services. The repository, which is an electronic storage area, allows health providers to share X-rays, CT scans and other diagnostic images and reports.

Morrow, CEO of Glengarry Memorial Hospital in Alexandria, Ont., says they connected in August. All diagnostic imaging is uploaded to a database, she explains, and participating health-care workers can access it (*Cornwall Standard-Freeholder*, Aug. 13).

At Brockville General Hospital, where Wilson is Manager of Diagnostic Imaging, "[the system] allows primary care providers to view images instantly regardless of where they were acquired," Wilson says, adding that nurses can "...ultimately provide better access to care for our patients." (*St. Lawrence EMC*, Aug 19)

Two-tier pay

RNAO member **Julia Fisher** is upset that non-unionized RNs didn't receive a three per cent raise on April 1, while 50,000 of their unionized colleagues did.

Traditionally the province will match raises, but following the

E NEWS

BY STACEY HALE

spring's provincial budget the match never came for thousands of non-unionized nurses. "We've always been paid the same. This will cost us big money," says Fisher, a day surgery nurse in Mississauga.

Although the discrepancy will even out when union-members' existing contract expires next March 31, hospitals are concerned the freeze is creating inequity between staff. "I don't know why they're doing this to us," Fisher told the *Mississauga News* (Sept. 2). "The government has created a two-tier pay schedule. We're being penalized."

Grief counseling

In August, RNAO member **Bev Wilson** spoke to the *Stoney Creek News* about her work with a local support group called Friends in Grief. The group works with bereaved adult women and men to help them cope with the death of a loved one. It was formed in 1985 by Joan Faria, who saw the need for a support group when she lost her son.

Wilson, who has worked in bereavement counseling for more than 20 years, says in the past decade there's been a change in attitudes about death. It's no longer a "hush-hush" topic, and support needs are growing, she says, adding that younger people are increasingly seeking help, in most cases to deal with the loss of a parent (Aug. 23).

The group sees more than 2,000 people a year, working with them for 10 weeks. They help in many ways, whether doing chores around the house or just lending an ear.

Nocturnal dialysis

For nine years, RNAO member **Marie-Eve Chainey** has battled kidney disease. It's a condition that has nearly killed her several times and forced her to endure some 800 blood transfusions. The 27-year-old University of Ottawa nursing student acheived an important goal this past summer when she competed in high jump during

PHOTO: CHRISTOPHER PIKE

Nursing student and track and field athlete Marie-Eve Chainey

the Canadian track and field championships in Toronto.

Chainey credits nocturnal hemodialysis for allowing her to begin training again three years ago. She undergoes dialysis for eight to nine hours while she sleeps, six nights a week. "When I got sick, the goal that I had was to just be back jumping," she says. "Jumping was basically my happy place ..." Chainey told the *Toronto Star* (Aug. 2).

Her objective now is to spread awareness about the benefits of nocturnal hemodialysis, which isn't widely available in Canada. "I got back my lifestyle," she says.

OUT AND ABOUT

BRING BACK LONG-FORM CENSUS

RNAO Director of Health and Nursing Policy Rob Milling addresses a news conference in Toronto about the federal government's hasty decision to cancel the mandatory long-form census (see pg. 25 for more). At media events held on Sept. 2 in Toronto, Sudbury, Winnipeg and Edmonton, nurses, medical officers of health, epidemiologists and others spoke out about the impact the cancellation will have on health-care data.

BPGs TRANSLATED TO SPANISH

On Aug. 12, RNAO Executive Director Doris Grinspun (left) and Teresa Moreno, Chief Executive Officer of Investén-isciii, signed an agreement that will see all of RNAO's 42 best practice guidelines translated into Spanish. The historic partnership with Spain was announced at a news conference at RNAO's head office, and means the guidelines will now benefit millions of Spanish-speaking nurses and patients around the world.

NURSING IN THE NEWS

NURSING NOTES

OUTSTANDING VOLUNTEER NOMINATED FOR NATIONAL AWARD

Valerie Rzepka, a nursing policy analyst at RNAO, has been nominated for a new national volunteer award sponsored by CBC News and Outpost Magazine for her work with the Canadian Medical Assistance Teams (CMAT). Since 2005, Rzepka has travelled to Pakistan, Bangladesh, China and Haiti to coordinate and oversee disaster relief projects and provide nursing care. She is currently CMAT's national chairperson. This fall, a panel will select ten finalists from all the nominees for *Canada's Champions of Change* and online voters will choose the winners. Two winners will receive $25,000 for their organization and each finalist will receive $10,000.

DISTINGUISHED ALUMNUS HONOURED AT CONVOCATION

RNAO member Margaret Campkin was recognized this past spring by Durham College for her contributions to the nursing and teaching professions. She received an Alumni of Distinction Award at convocation ceremony in June. Campkin, who graduated from Durham's nursing program in 1985, has been a part-time instructor in the Critical Care Nursing Program at the college since 2007. She began her nursing career in the hospital sector, working on the medical isolation unit and then in critical care at Lakeridge Health in Oshawa. She is now patient care manager for critical care at Lakeridge.

RNAO APP READY FOR DOWNLOAD

If you have an iPhone or iPod touch, you can now access RNAO's Nursing Best Practice Guidelines (BPG) from your pocket. On Aug. 30, RNAO began offering nurses an application (or "app" as it is commonly known) for sale through iTunes to access up-to-date, evidence-based research at your fingertips. To date, the app has been downloaded 906 times in Canada, and 183 times in other parts of the world, including the U.S., South America, Australia, Europe and Asia. For only 99 cents, nurses can find many of RNAO's 42 clinical and healthy work environment BPGs. Similar apps for Blackberry and Android devices are coming soon. Visit www.rnao.org for a link to iTunes, and for PDF versions of each BPG.

Team work

RNAO member **Chris Thrasher** wrote an editorial in the *Windsor Star* explaining the importance of collaboration among health-care professionals. The associate nursing professor at the University of Windsor voiced concerns that the health system revolves around physicians.

"We should be paying attention to the other health professionals who deliver care ... specifically registered nurses who are actually the primary care providers in the hospital," Thrasher wrote.

Thrasher argued that hospitals could go a long way to solving "problematic work cultures" if MDs were viewed as part of a team, and not "the team," "gatekeepers," or always "captain of the team." She believes a change in culture is long overdue. "Let's give other members of the health-care team greater voice, and a greater share of the decision-making powers." (Aug. 31)

Ready to collaborate

In August, RNAO President **David McNeil** and Executive Director **Doris Grinspun** expressed publicly that the association is ready and willing to work with the new president of the Canadian Medical Association (CMA).

Nurses were pleased to hear Dr. Jeff Turnbull endorse the principles of the *Canada Health Act* during his inaugural address to the CMA's annual meeting in August. His "job is now to ensure that the CMA's policies and values are aligned with his own views, which reflect those of the Canadian public," McNeil told the *Sudbury Star* (Aug 31).

Turnbull, who provides clinical care to Ottawa's homeless, understands the health impact of social determinants such as poverty, housing and nutrition. "We are ready to collaborate...to make equity and social justice in Canada a reality," Grinspun said.

On Aug. 7, RNAO member and Canadian Nurses Association President Judith Shamian wrote a letter to the National Post in response to an editorial calling for more private, for-profit funding in the health system.

Two-tiered health care won't work

Canada's registered nurses vigorously disagree with your editorial's suggestion that creating "a hybrid system that permits private health-funding options in parallel with a publicly-funded universal health system" is the answer. A two-tiered system would simply widen the health-care gulf between the rich and the not-so-rich, and make the overall system more expensive. Streamlining the way resources are used across the system would be far more productive. Nurse practitioners, for example, can provide excellent access for the five million Canadians who have no access to primary care. And placing greater focus on team-based health care to manage chronic illness, mental health and health promotion will lead to a healthier population and reduced health-care expenses.

JUDITH SHAMIAN, PRESIDENT
CANADIAN NURSES ASSOCIATION

Plugged in

RN USES TECHNOLOGY AS A PLATFORM TO SHOW THE WORLD WHAT NURSES DO.

When he got his first iPod in high school, Rob Fraser started downloading audio books and lectures to satisfy his appetite for knowledge. That hunger intensified when he got to university. He was studying nursing at Ryerson University and found he was searching for nursing and health science lectures to watch online. He was surprised to come up short.

"There was a gap," recalls the soft-spoken 24-year-old, who was inspired to become a nurse after doing volunteer work in India and the Caribbean. The profession had a scarce presence online, which for Fraser meant future nurses and the public couldn't discover all the great things about nursing.

That's when the light bulb went on. He could help fill the technology gap.

As a student, Fraser was always taking part in nursing conferences and did a placement at RNAO. "I did have a bit of access, and knew some nursing leaders," he says. His hope was to have a dialogue on camera with those leaders, then share their knowledge and passion by making the video available online.

His involvement in RNAO opened his eyes to things like best practice guidelines, violence in the workplace and other nursing issues. He says this helped him better understand his school work. "I'd understand at a level that was a bit deeper than some of my classmates," he says. "It wasn't because I was smarter or studied harder; it was because I was so involved." Fraser wanted his colleagues to have the same access to information, and to nurses he thought were inspiring.

Doris Grinspun, RNAO's executive director, was his first interview. He used his laptop propped up by a stack of books to shoot it. After he uploaded the video online, he started thinking about his next profile. Today, those videos feature nurse leaders and health researchers discussing their work. Street nurse Cathy Crowe and journalist Suzanne Gordon are just a few of the interviews on his website called *Nursing Ideas* (www.nursingideas.ca).

Three things you don't know about RN Rob Fraser

1. Fraser is completing a master's degree in nursing administration at the University of Toronto.
2. He was director of mountain biking for a children's summer camp in Huntsville, Ontario.
3. He plays acoustic guitar.

Since he launched the website in 2008, it has drawn more than 15,000 viewers from around the world. Thousands have downloaded his podcasts on topics ranging from research ethics and men in nursing to caring with cultural competency. *Nursing Ideas* also links to Fraser's blog and Twitter page, where he shares tips on how to use the latest tech gadgets.

Fraser believes it's important for nurses to get involved in technology and social media. He knows from experience that social media works. While still a student, Fraser was updating a hospital policy on nasogastric tube placement and found researchers were undecided on the best way to check if a medication/feeding tube was in a patient's stomach, where it belonged, rather than in the lungs. To see if the research was in sync with reality, Fraser turned to his followers on Twitter. He posted the question and nearly 25 nurses responded, each describing a different testing method in their respective workplaces. Fraser concluded there wasn't a standardized approach, which was consistent with the research.

Although his conclusion was not scientific, Fraser found it helpful to connect with fellow RNs to explore processes in their organizations: "It was the first time it clicked that (social media) is a real connection with people who are working at different hospitals and have knowledge to share."

Fraser hopes *Nursing Ideas* and websites like it will boost nursing's presence on the internet, which he says is critical if we want to increase public awareness of the profession.

His next project will take him out of cyberspace and into book publishing in an attempt to help equip RNs who are reluctant to embrace online communities. He's writing a book that will explain the basics of social media, including the myriad of websites, how to set up a profile, and tips and advice about online etiquette. **RN**

STACEY HALE IS EDITORIAL ASSISTANT AT RNAO

PHOTO: TANJA-TIZIANA

FROM provider TO patient

A look at how RNs are changing their practice thanks to personal experiences from a patient perspective. **BY JILL-MARIE BURKE**

There's no better way to understand the needs of patients than by being one yourself. At least that's what RNAO members have said in response to our call for stories about what it's like to experience care from the other side of the bed. There are countless lessons RNs can learn on the receiving end of care, but we've zeroed in on seven of the most common. Whether it's a renewed commitment to developing therapeutic relationships; advocating for the timely delivery of test results; a calmer demeanor; a desire to expand nursing's scope of practice; or a keener sense of the importance of basic nursing skills: RNAO members are changing the way they practice thanks to their 'awakening.'

AFTER THE STORM

When Beverley Fedoroff was doing a preceptorship with Saint Elizabeth Health Care, many of the clients she and her preceptor visited had breast cancer. During the rotation, Fedoroff became aware of a pain in her own breast, but

RN and cancer survivor Beverley Fedoroff stands in front of a Princess Margaret Hospital statue honouring those who have raised money to support breast cancer research.

PHOTO: HENRIETA HANISKOVA

first thought it was psychosomatic. A few weeks later, at age 37, she discovered it wasn't in her head. She was diagnosed with breast cancer and underwent surgery, chemotherapy and hormonal therapy. Throughout the journey from diagnosis to treatment and symptom management, the nurses Fedoroff encountered were knowledgeable and compassionate. She was even able to arrange for her preceptor (a breast cancer survivor herself) to provide her home care. When her treatment ended three years ago, Fedoroff would have liked to discuss the emotional, psychological and sexual side effects of breast cancer surgery and treatments with a nurse. But she found that when active treatment ended, so did the role of nurses. Instead, she went online and found a supportive community of women willing to share information and tell her what to expect next.

HOW THIS EXPERIENCE CHANGED MY PRACTICE

Nurses currently play an important role in helping women manage the physical symptoms of breast cancer, but Fedoroff wants nurses to become more involved in providing emotional support: "When they are first diagnosed, women ask themselves 'Am I going to live or die?' But once the threat of death is gone, they need to deal with how they're going to look physically and how this is going to affect them sexually." Fedoroff, who experienced menopausal symptoms while receiving injections of Goserelin, says mental health issues related to breast cancer are equally as important as physical issues. She'd like to see nurses fill this gap in the system.

LOOKS CAN BE DECEIVING

On the last day of classes before summer vacation, University of Western Ontario nursing student Melina Hutchison was admitted to hospital for five days to receive IV steroids to treat her Crohn's Disease. At 26, Hutchison was one of the youngest and most mobile patients on the general medicine unit. Since she could feed herself and go to the bathroom on her own, the only time she came into contact with nurses was when they came to check her IV or assist her elderly roommate. She says because she was amenable and didn't demand a lot of attention, she felt the nurses considered her to be an "easy" patient. But nobody realized she was feeling scared, lonely and a bit depressed.

HOW THIS EXPERIENCE CHANGED MY PRACTICE

Hutchison, who just entered the final year of the compressed BScN program, says she wants to develop the kind of therapeutic relationship with patients that she's learned about in class. If she encounters a quiet, low-maintenance patient like herself, she says she'll ask open-ended questions like: Do you need anything else besides this drug? How are you handling all this? Is there anything else we can do? Do you need to talk to somebody? This is a great way to find out how they're really doing and feeling, she says. Hutchison admits she's a private person, but says "if someone sat down to talk to me, maybe I would have opened up a bit." Since she rarely talks about her disease in her personal life, she says she would have appreciated the opportunity to vent for a few minutes. "If I have a patient like me, I'll dig a bit deeper," she vows. "Maybe there's something psychological that they need help with."

AGENTS OF CHANGE

It wasn't the pregnancy that prenatal educator Suzanne Bell had envisioned for herself. After developing severe pre-eclampsia (hypertension) in her 24th week, the London public health nurse spent eight weeks on bedrest – three at home and five in the hospital. Placed on a ward with moms and healthy infants, she felt unprepared for the situation she found herself in and lay there worrying about whether her own baby was going to be all right . She struggled with isolation, boredom and loneliness. In her 32nd week, she had an emergency c-section and delivered a 4 lb. 15 oz daughter. She couldn't see her newborn, Emma, for the first 48 hours because Emma was in the Pediatric Critical Care Unit (PCCU) and Bell had to stay in the labour and delivery area under direct care. She wondered if the prolonged separation might make it difficult for them to bond later.

HOW THIS EXPERIENCE CHANGED MY PRACTICE

Bell used to teach prenatal classes at Middlesex-London Health Unit but now co-coordinates the prenatal education program. She is also involved in keeping the curriculum updated. Her daughter is now a healthy 6-year-old but Bell says the pregnancy made her realize the importance of having a discussion with parents-to-be that pregnancy and birth don't always go exactly as we plan. Statistics show that 16 per cent of first time moms in southwestern Ontario will have c-sections, and many of those will be unplanned, just like Bell's. "Yes, go into the experience with a birth plan and, yes, be really excited in dreaming how you'd like your birth to be," Bell tells parents, "but know that at any given point that plan can change. It is better to be open-minded and flexible. Each person's experience will be different."

THE POWERS OF OBSERVATION

Greg Beard was feeding cattle on his farm outside Tillsonburg when he suddenly felt like his head was going to explode. When the headache ended, extreme nausea set in and he started to feel stiff and sore. He went to his local hospital where a resident diagnosed him with the flu and sent him home. A week later, the extreme stiffness was making it difficult to move. "You've still got the flu," the same resident told him when he went back to the hospital. Two days later, when he couldn't bend over or move his head, his wife took him to see his family physician. The doctor took one look at Beard and said he either had meningitis or had experienced internal bleeding.

Turns out, Beard had suffered an aneurism and beat all the odds by surviving the condition and subsequent surgery. Three days after the burst artery was repaired, a nursing student noticed his left hand had gone limp while giving him a bed bath. She ran out of the room to report that he was having a stroke.

Tillsonburg RN Greg Beard beat all the odds and survived an aneurism after being misdiagnosed with the flu. Years later he became an RN, and now works in rehab at London's Parkwood Hospital.

PHOTO: JEFF TRIBE

PHOTO: SANDI KRASOWSKI

Thunder Bay RN Mary Lee Barry and husband Bruce LaMarche share a new appreciation for clarity and calm when discussing illness with health professionals.

HOW THIS EXPERIENCE CHANGED MY PRACTICE

Assessing patients is a difficult, but extremely important skill for nurses, Beard says. Since his aneurism occurred during flu season and the symptoms are similar, he isn't surprised the resident misdiagnosed him. The experience taught him to follow up on what a patient is telling you, even if you think their concerns are unfounded: "It's important to ask a second question, to take a second look."

The misdiagnosis could have had deadly results for Beard, but his family physician's quick assessment saved his life. He's also grateful to the student nurse who applied her assessment skills: "If that girl hadn't given me a bed bath and encouraged me to participate, I could have been laying there for hours and nobody would have known I was having a stroke."

CALM, COOL AND COLLECTED

Mary Lee Barry was still in shock from the news of her breast cancer diagnosis when she walked through the doors of the Cancer Centre at Thunder Bay Regional Health Sciences Centre. When Barry, her husband and a close friend sat down with the oncology RN to discuss her medical history, she could barely state her own name. The nurse's manner, however, put her at ease. "She was very calm and reassuring, pleasant and easy to talk to," says Barry. "She made eye contact and didn't rush. I walked in there feeling terrified, but by the end of the hour, everyone felt good and we were enjoying her company."

HOW THIS EXPERIENCE CHANGED MY PRACTICE

Barry learned that a nurse's demeanour can have a significant impact on how a patient feels about his or her condition. She says that if a nurse is calm, the patient will feel more relaxed and comfortable, and maybe even more optimistic. Barry spent three years as a nurse with Bayshore Home Health and cared for women at all stages of breast cancer. Today, she provides home foot care and also conducts assessments for Veterans Affairs Canada. When she reflects on her own practice, she realizes there may have been instances when she asked too many questions instead of just listening actively. "Today I try to be very calm and aware of how my composure affects patients."

MIXED MESSAGES

It was a rainy July afternoon when RN Juanita Kuhl and her family had a car accident on their way to a family reunion in Ottawa. Kuhl's husband was behind the wheel when the car skidded on water on a section of highway in cottage country, knocked out three guard rails and rolled down an 18 metre embankment. From the angle of his body and his obvious head injuries, Kuhl first thought her husband was dead. But when she and her daughter were helped out of the car by passersby, she heard him moan. The family was taken to a community hospital where Kuhl and her husband were assessed in separate treatment areas. Their

"If I know a patient is waiting for a test result that could change their life, I'll phone up the specialist's office and say 'this is what they're going through."

Port Elgin RN Rona Cobean on the importance of timely test results for patients and families.

Rona Cobean

PHOTO: PETER MCNEICE

daughter went back and forth between the two areas checking on her parents. One-and-a-half hours into their traumatic ordeal, Kuhl and her daughter where shocked when a nurse suddenly appeared beside them and announced: "We're going to wheel your husband in so you can both say goodbye." It sounded so final that the women believed he was about to die. The nurse noticed their dismay and clarified: "We feel your husband has some internal injuries we can't deal with here so we need to get him to a larger trauma centre."

HOW THIS EXPERIENCE CHANGED MY PRACTICE

Think before you speak. That was the lesson Kuhl took away from her experience with the health system. In fact, she now takes an extra moment or two to ask herself 'How are they going to interpret this?' before she talks to patients and their families. "I try to run most things through my head before I blurt them out because what the patient is hearing might not be your intended message," she says. "I've been on the other side and I know how (a misunderstanding) can impact somebody."

THE WAITING GAME

During a New Year's lunch with family and friends, 13-year-old Caitlyn Cobean told her mother, Rona, that she couldn't see anything. She complained of having the worst headache of her life. By the time the family reached the hospital, Caitlyn didn't know where or who she was. A CAT scan quickly identified a troubling shadow in Caitlyn's brain. An MRI was performed the next morning, but the family had to wait all day for the radiologist to give them the test results. The news and prognosis weren't good. Caitlyn had an inoperable cancerous tumor and died 19 months later.

HOW THIS EXPERIENCE CHANGED MY PRACTICE

Rona Cobean, who has been working in a doctor's office in Port Elgin for 10 years, says experiencing the health-care system as the mother of a terminally-ill child has made her a more understanding and compassionate nurse. It's also motivated her to do everything in her power to see that patients receive their test results as soon as possible.

"Sometimes delays are necessary, but other times they occur because staff get caught up in the day-to-day routine of running an office," she explains.

Occasionally, Cobean needs to "pull the Caitlyn card" and tell the story of her family's experience in order to convey the stress and agony of waiting for test results. "If I know a patient is waiting for a test result that could change their life, I'll phone up the specialist's office and say 'this is what they're going through,'" she says. **RN**

JILL-MARIE BURKE IS COMMUNICATIONS OFFICER/WRITER AT RNAO.

myths about long-term care nursing

Ageist assumptions about caring for the elderly may deter RNs from choosing to work in this rewarding specialty. **BY LESLEY YOUNG**

IF you've never nursed in long-term care (LTC), you're probably harbouring at least one misconception about the sector. But don't feel too bad, there are a lot of reasons why; maybe one of your student clinical placements gave you the wrong impression, perhaps someone told you the pay is bad, or you likely assumed that dolling out oodles of medicine all day couldn't be that challenging, not stacked against the fast-paced, glamourous world of acute care nursing in the ER or ICU, right?

"When I teach our first-year nursing program, I ask the group of students where they see themselves five years after graduation. I can count on a pinhead the number interested in gerontology nursing," says Beryl Cable-Williams, RN and faculty member at the Trent/Fleming School of Nursing at Peterborough's Trent University. Later in the program she asks students about their work in ER and ICU. They often talk about the diagnoses of the clients. But when she asks, "What is the average age of your patients?" they always pause and say, "You got me!"

Cable-Williams' point is that many patients in acute care are elderly, and that's only expected to increase given the major demographic shift afoot in Canada. In 2026, one in five Canadians will be over the age of 65; in 2001 it was one in eight. That means many of the ageist assumptions we are guilty of making about caring for the elderly are increasingly less exclusive to long-term care (especially since acute care is overloaded with complex cases). In addition, the field's never quite lived up to its image as the place one goes to take on casual work or to get a "break" (as some unsuspecting nurses have discovered).

In fact, you may just find, what with increasing media attention, new *Long-Term Care Homes Act* regulations in Ontario, and growing awareness of the importance of LTC, that gerontology could be the new "in" career in nursing. Okay, so most RNs in LTC agree we're a few years away from the next Grey's Anatomy being set in a nursing home, but they are eager to bust some of the more pervasive myths and cast the image of LTC in a more positive and realistic light.

I'LL LOSE MY SKILLS IF I GET INTO LTC NURSING

Of all the misperceptions that surround the field, this one is the most omnipresent, according to RNs in LTC. Cable-Williams contends that initial placements in LTC leave students with the wrong impression because they typically get exposed to only basic skill development. "It's a good early experience for skill development, but it gives them a skewed notion of what LTC is all about."

Saima Shaikh, a Toronto-based LTC RN for 15 years, says: "If anything, long-term care nursing requires superb leadership skills and outstanding assessment skills." She explains there is often only one RN on duty in a LTC setting, and that nurse is responsible for supervising large numbers of staff. "You're also working collaboratively with doctors. The RN is there 24/7 and it's her judgment and her critical thinking that are called upon. She's the one who picks up the phone to reach the on-call doctor."

Shaikh and others are quick to point out how patients in LTC are not the same as they were 20 years ago. "Their needs are far more complex. We've got special needs happening with oxygen, IVs, feeding tubes and catheters, and behavioural issues, for example." Those needs constantly test nursing skills and demand best practice knowledge. Nurses in LTC also develop excellent communication and interpersonal skills, she adds. "Families are informed advocates for family members. You have to be able to communicate, apply diplomacy and negotiate all of the time."

LTC IS THE BACKWATER OF NURSING

RN Pamela Rowe proudly points out that her facility, Region of Durham Hillsdale Estates in Oshawa (where she is manager of nursing practice), is one of the only LTC homes in Durham Region that offers peritoneal dialysis on-site. "We are extremely progressive in our treatments," she notes, adding that LTC, while still in need of better funding, is hardly a backwater of nursing. "Our staff are well trained in infection control, antibiotic therapy via IV, G-tube feeding, catheters, patient controlled analgesia pumps, oxygen therapy, subcutaneous and intramuscular injections, suctioning and wound care." She adds that she's seen acute care nurses who move to LTC who don't know how to use the latest wound vac machines, which provide state-of-the-art wound care therapy that creates fewer disturbances to the wound and less discomfort. Cable-Williams points out that LTC was a pioneer of the social model of caring, which shifted the focus away from seeing residents as patients.

WHEN I NEED CASUAL WORK, I'LL TRY LTC BECAUSE IT IS SO EASY AND SLOW-PACED

Just like every field of nursing, LTC has its own unique, intense demands. To assume that it is easier than another field, which nurses often do (including Shaikh, who switched from acute care to LTC after having kids), is a big mistake. "I've had staff come from a hospital setting, who, after two weeks, can't do it," says Shaikh. "The patient load is 30 residents to one nurse. You're supervising unregulated health-care workers. There's also 30 sets of families (of residents) to communicate with on a regular basis. Plus there's hefty case management, what with liaisons between specialists such as dietitians, massage therapists, doctors, the family and that's not counting the medication..." Add to that needs of residents, and, well, point taken.

THE PAY IS BAD IN LTC NURSING

RN Joni Wilson, Director of Care at Peterborough's St. Joseph's at Fleming, a LTC facility, says her pay is on par with RNs at hospitals. Rowe at Hillsdale Estates adds that Durham Region provides excellent benefits and wages to its nursing staff. While both admit there are some LTC homes that might not pay as much as they should, that is fast becoming the exception, not the rule. With the shortage of RNs in LTC, organizations like St. Joseph's at Fleming are using everything they can to hold on to staff, adds Wilson. A quick assessment of the demographic shift and shortage of nurses suggests the situation will continue to work in nurses' favour.

"An RN in long-term care is very much part of the leadership team. And you can change clinical outcomes for residents."

Saima Shaikh, a Toronto-based LTC RN for 15 years

I'LL JUST BE SPINNING MY WHEELS IN LTC

Because of the nature of LTC — one RN often oversees an entire floor — nurses have true opportunities to affect practice change and the culture of the environment, according to Shaikh. "An RN in long-term care is very much part of the leadership team. And you can change clinical outcomes for residents." For example, she says, you can develop a continence management program for a floor, or put together a fall prevention program to minimize injuries. You can even take on a leadership role in implementing an RNAO best practice guideline. The bonus? Thanks to the "long" in LTC, you really get to witness the results of care in residents over the long run, unlike other settings where patients come and go as quickly as your shifts.

PATIENTS GO TO LTC TO DIE

This myth goes hand-in-hand with the stigma that LTC is depressing. Says Wilson: "People do improve once they come into LTC. Often, they have not been getting the kind of care they need and when they do, the turnaround can be remarkable." She recalls how one resident on a secured unit took ownership over weeding in the garden. "He was able to feel like he was doing something, that he was needed. It alleviated some of his anxiety and prevented some behavioural issues."

Wilson believes LTC nursing also allows nurses to be advocates for a group of people who are vulnerable and often treated as unimportant in our society's culture. "They've lived long and they deserve the best quality care, the same as anyone in intensive care would have and it is especially important that we develop best practices."

Cable-Williams points out that in order to break down some of the stigma surrounding LTC, we need to recognize that we're struggling with a false dichotomy by trying to separate living from dying. "We need to imagine living and dying occurring simultaneously, and that while we're doing that, we are having the best life possible." She adds that it is remarkable how many nursing students have not spoken with someone in their 80s and 90s. "They are always surprised by how cool residents are. When you get a chance to see life as it has been lived by these octogenarians and nonagenarians, and you project your own life into the future, it opens a door on what it means to be human. It encourages our own humanness, which is helpful to nurses interacting with patients at any stage of life."

I WON'T GET TO DO ANY BEDSIDE CARING IN LTC

Every nurse interviewed for this article said this just isn't true. While there is plenty of administrative work for the RNs in LTC, there are also many opportunities to provide hands-on care for residents. "You do not lose touch with your bedside nursing abilities," says Shaikh. She explains that RNs get to know residents over a very long time. "They share stories with you and you build relationships. You get close with their families. It's a more intimate type of nursing." And while you care for residents in hands-on situations, you also get to see the results of big picture policy work from a practice perspective.

LTC SETTINGS AREN'T THE GOLD STANDARD FOR CARE

Cable-Williams says the media are largely responsible for a negative image of LTC environments. "It is rare to see LTC settings and the nurses who work there portrayed positively in the media. For example, a recent *Metroland* series entitled "Crisis in Long-Term Care" highlighted the shortcomings of the system, but did not provide any perspectives from residents and families who are very satisfied with their experiences." Nursing homes have a dismal heritage as the poor houses of decades ago, explains Cable-Willams. "More recently, standards and regulations have gone a long way to addressing many of the inadequacies of older models of care. However, the old images persist in the collective imagination of many of the public." In her research in LTC homes, Cable-Williams found many examples of deeply caring, dedicated staff and residents who think the world of the staff. The culture that exists inside LTC homes is quite different from other nursing settings, in a surprisingly wonderful way, adds Rowe. She explains how Hillsdale Estates is a modern, friendly, resident-focused environment supported by pet therapy, such as birds, cats and fish tanks throughout the home. A fireplace, spacious homey sitting areas, a tuck shop and a café all welcome you as you enter the home. "It's so inviting when you walk in the door…there's a lot of personality … inside these walls."

"LTC nursing also allows nurses to be advocates for a group of people who are vulnerable and often treated as unimportant."

Joni Wilson, Director of Care, St. Joseph's at Fleming

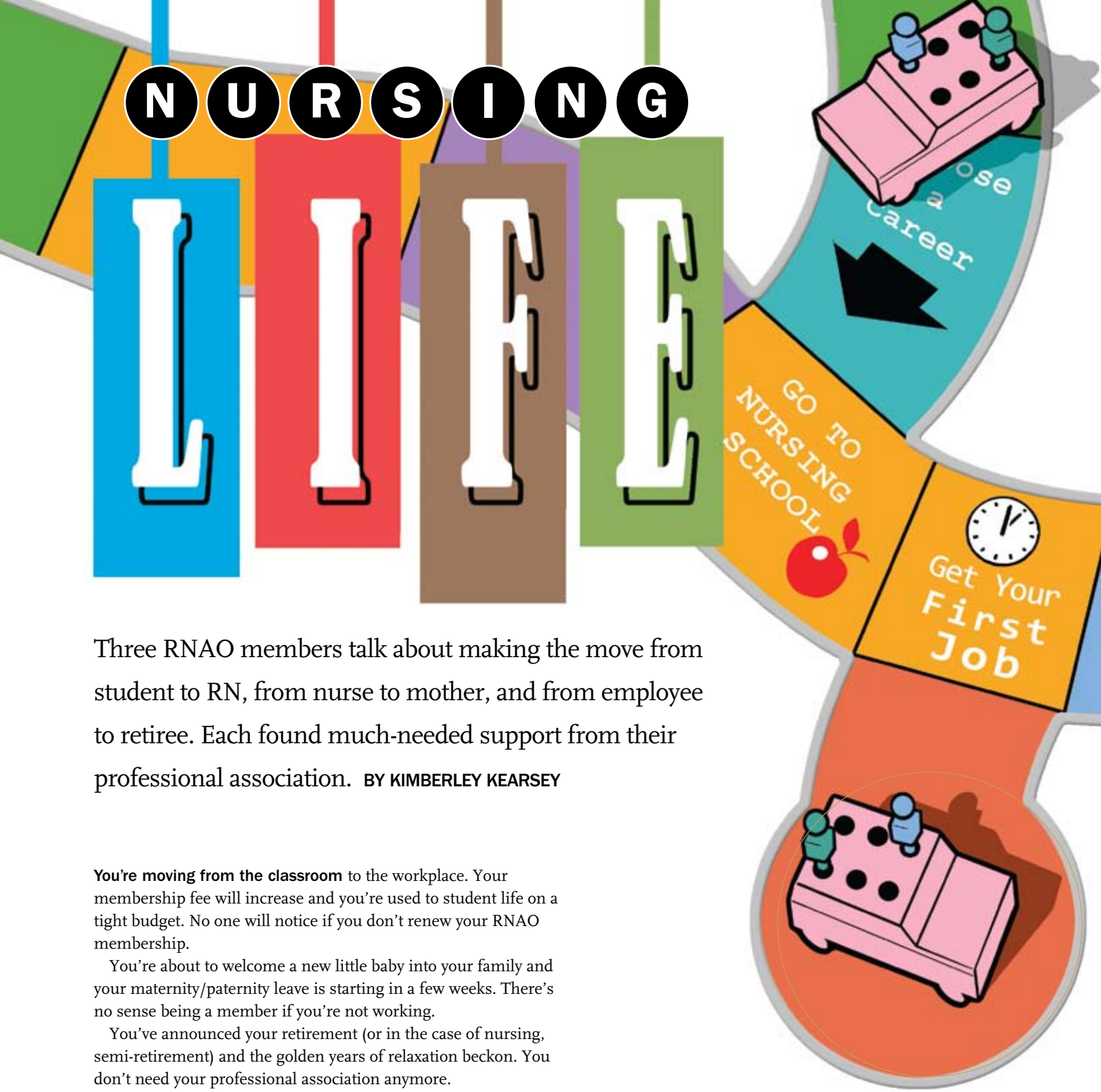
RNs ARE TOTALLY ON THEIR OWN IN LTC NURSING

Mary Bawden, RN and nursing professor at the University of Western Ontario in London, refutes the notion that RNs work in isolation. "You get a real sense of being a part of a team in LTC. You work with registered practical nurses and personal support workers, and develop incredibly strong working relationships." Rowe adds that it's necessary to establish professional trust with staff in order to stay on top of residents' health because they are often the closest with residents.

LTC NURSING IS NOT FULFILLING

Every single nurse interviewed for this article said that LTC nursing is a more intimate kind of nursing, the kind that enables you to develop long-lasting, enriching attachments to your patients. "I think staff in LTC fall in love with their clients. They'll often go to their funerals," says Bawden. Rowe, who has practised in acute care in the past, says former roles never allowed her to offer those little extras for patients. "I never had enough time for those extras. Just to sit at the bedside, take the time to hold a resident's hand, and talk about whatever bothers them that day." The smiles you receive and the relationships you build in LTC nursing are priceless, she adds. "It's both enriching and an honour to work in LTC. You can't underestimate the trusting relationships you form with each and every resident. What your heart puts into it, you receive back tenfold." **RN**

LESLEY YOUNG IS A FREELANCE WRITER AND EDITOR IN NEWMARKET.



Three RNAO members talk about making the move from student to RN, from nurse to mother, and from employee to retiree. Each found much-needed support from their professional association. **BY KIMBERLEY KEARSEY**

You're moving from the classroom to the workplace. Your membership fee will increase and you're used to student life on a tight budget. No one will notice if you don't renew your RNAO membership.

You're about to welcome a new little baby into your family and your maternity/paternity leave is starting in a few weeks. There's no sense being a member if you're not working.

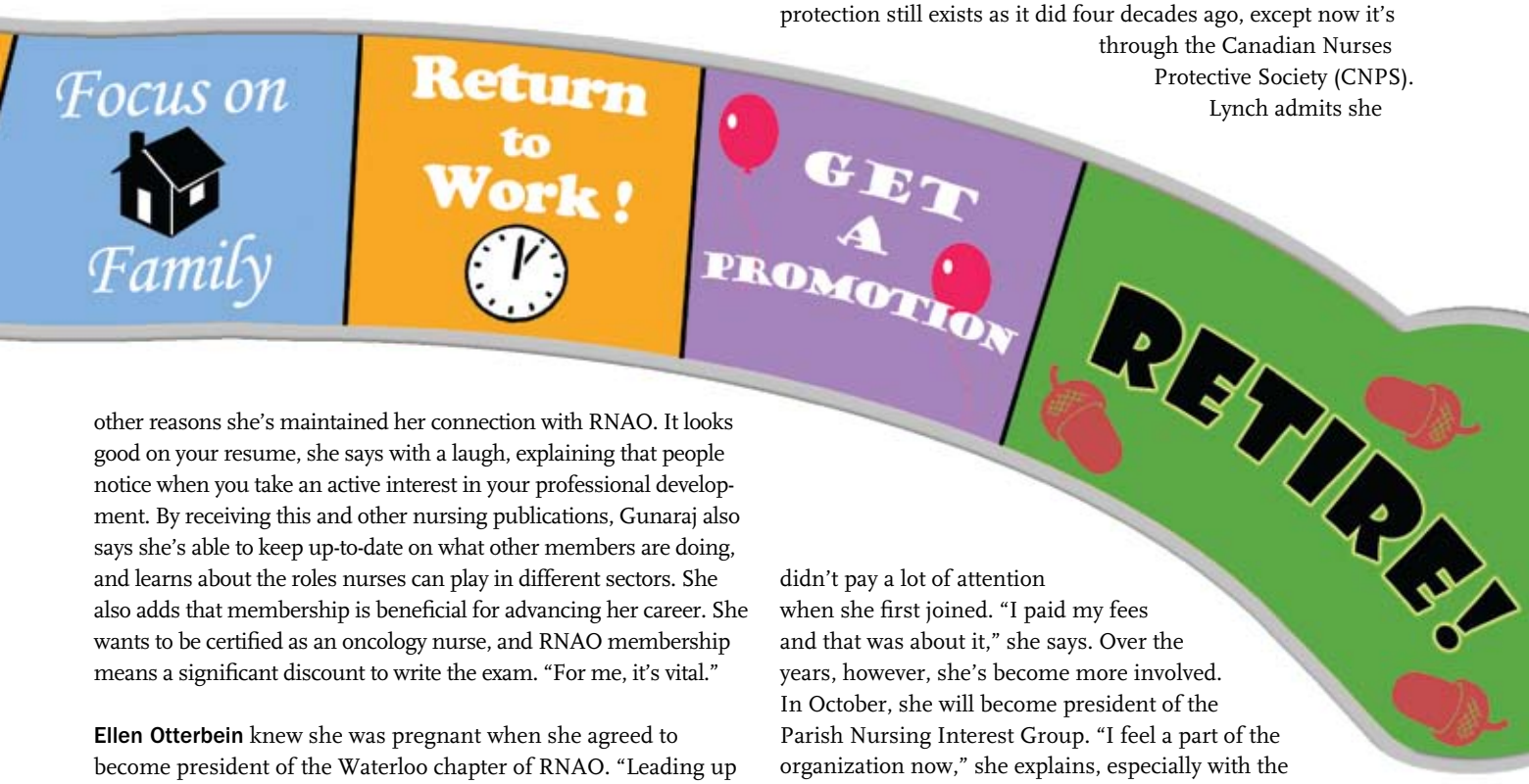
You've announced your retirement (or in the case of nursing, semi-retirement) and the golden years of relaxation beckon. You don't need your professional association anymore.

False. False. And...false.

These scenarios represent some of the most important transitions in our lives. They are moments that can be both personally and professionally challenging. As such, many people look to their personal and professional support networks to navigate their way through unchartered waters. Here at RNAO, however, they are moments during which some nurses decide to walk away from their professional association. RNs Madhu Gunaraj, Ellen Otterbein and Mary Lynch tell us why they've never broken ties, and what they tell colleagues when they hear them say they don't need RNAO.

ILLUSTRATION BY JASON SCHNEIDER

Madhu Gunaraj graduated from Ryerson University two years ago. "It's kind of scary going out into the real world," she says. "You think of worst-case-scenarios when you've graduated." That's why it was almost a no-brainer for her to maintain her membership, if only to be able to access the association's Legal Assistance Program (LAP). "Having that back-up is important," she says of the program, which provides members with financial support for access to legal counsel. It covers: appearances before the College of Nurses of Ontario as a result of a letter of complaint, a report or other investigation; court appearances as a witness at an inquest or inquiry, under subpoena, or in a court proceeding; sexual harassment; and a variety of other employment-related matters. Gunaraj says she's shocked when other nurses tell her they haven't signed on. "That caught me by surprise," she notes of a recent conversation with two fellow grads who let their memberships lapse. "I think it's wonderful that it's available. Not every profession has that." Gunaraj isn't shy about sharing some other reasons she's maintained her connection with RNAO. It looks good on your resume, she says with a laugh, explaining that people notice when you take an active interest in your professional development. By receiving this and other nursing publications, Gunaraj also says she's able to keep up-to-date on what other members are doing, and learns about the roles nurses can play in different sectors. She also adds that membership is beneficial for advancing her career. She wants to be certified as an oncology nurse, and RNAO membership means a significant discount to write the exam. "For me, it's vital."



Ellen Otterbein knew she was pregnant when she agreed to become president of the Waterloo chapter of RNAO. "Leading up to my maternity leave, I was thinking this is a really good time to focus on the chapter," she says. "Since I don't have to think about work, I can feed the baby and think about something else." The new mom also notes that letting her membership lapse didn't even occur to her at any time before or after she gave birth to a little girl in March of 2009. "As much as I was busy with my new baby, I really wanted that connection. It was such a huge adjustment to go from being on my own to being a parent," she explains. "And at some point you have to go back...to not have a membership and be off without connecting with anyone I think puts you at a disadvantage when you go back." Just because you're on maternity leave doesn't mean you're no longer a nurse, Otterbein says. The networking opportunities alone were one of the biggest draws for this infection control consultant. They are valuable whether you're working or on leave, she says. "Missing the AGM or assembly meetings, those are really rich opportunities to connect with other people and do that networking. They're invaluable...in truth, if you miss them, you really miss out." Otterbein laughs when she talks about taking her one-month-old baby to the 2009 AGM and admits that if she were to become pregnant and go on maternity leave a second time, she'd do it again. "Life doesn't stop just because you're having a baby."

Mary Lynch retired seven years ago, and like many of her retired colleagues, she's still hard at work. In fact, she spends 20-30 hours each month working casually in rehab and stroke recovery at Lakeridge Health, a large hospital in Durham Region. She also volunteers as a nurse in her parish. "People always ask me 'why are you paying all that money into RNAO?'" she says with a laugh. Her response is simple: "I can't afford to be without it." Lynch first joined the association in 1972. She was a home-care nurse and in need of liability protection. Decades later, her legal needs are taken care of thanks to LAP (established in 1986). Her liability protection still exists as it did four decades ago, except now it's through the Canadian Nurses Protective Society (CNPS). Lynch admits she didn't pay a lot of attention when she first joined. "I paid my fees and that was about it," she says. Over the years, however, she's become more involved. In October, she will become president of the Parish Nursing Interest Group. "I feel a part of the organization now," she explains, especially with the creation of *members' voices* at association assembly and board meetings. Each year, members are invited to share with colleagues and the board their activities and accomplishments. "I feel like my professional association has invited us to participate... our opinion seems to count," she says. Political action has also become a passion for Lynch in recent years. She remembers feeling particularly proud of her involvement in a poverty march in Toronto in the fall of 2008. She also brings local health and ethical care issues to her MPP whenever she can. She says speaking out as an advocate for people who really need nurses' input drives her to continue her membership with RNAO. **RN**

KIMBERLEY KEARSEY IS MANAGING EDITOR AT RNAO.

WANT TO KNOW MORE
Read about how LAP can protect you at www.rnao.org/lap.

NPUpdate

New nurse practitioner-led clinics open, and more are expected

In the three years since Canada's first nurse practitioner-led clinic opened its doors in Sudbury on August 30, 2007, there have been a number of follow-up funding announcements from the McGuinty government that will fundamentally change primary health care and the impact NPs are having on the health of Ontarians.

The first wave of NP-led clinics to receive funding got word in February 2009. The second, in November that same year. And the third, just this past August. In all, 25 clinics are expected to be open within the next year. This summer, three sites officially opened their doors in Belleville, Belle River and London.

"Nurse practitioner-led clinics are becoming an integral part of health care in Ontario," Minister of Health and Long-Term Care Deb Matthews said at an official ribbon-cutting in London. "This investment means more access to quality health care closer to home for Ontarians." **RN**

(TOP) On Aug. 13, Ontario Premier Dalton McGuinty, Minister of Education and Prince Edward-Hastings MPP Leona Dombrowsky (left), and NP Tammy Armstrong announce the opening of Belleville's new NP-led clinic. "We're going to expand primary health care for individuals in the community," Armstrong, acting executive lead for the clinic, said.

(BOTTOM) On Aug. 23, Minister of Health Deb Matthews (left) visited Merrymount Children's Centre in London to announce the third wave of funding for NP-led clinics across the province. Joining her are (L to R): Wendy Vlasic, executive member for RNAO's Middlesex-Elgin chapter, Cheryl Yost, region 2 board member, Laurie McKellar, Middlesex-Elgin voting delegate, and RNAO Executive Director Doris Grinspun.

THE SITES (in alphabetical order):

Barrie	French River	London	Peterborough	Sudbury (pilot)
Belle River	Glengarry	Niagara Falls South	Sarnia	Sutton
Belleville	Huntsville	North Bay	Sault Ste. Marie	Thessalon
Capreol	Ingersoll	Oro Station	Scarborough	Thunder Bay (2)
Essex	Kitchener	Oshawa	Smith Falls	Toronto

PHOTOS: TOP: KEVIN FUNG; BOTTOM: NICK STEINBURG

POLICY AT WORK

Ongoing concerns about changes to special diet allowance

More than 136,000 people living on low incomes across Ontario rely on the Special Diet Allowance program to meet costly dietary needs due to health conditions such as diabetes, heart disease, or food allergies.

In its annual budget in March, the provincial government announced it was scrapping the program and replacing with a new nutritional supplement. At the time, Premier McGuinty said his government wanted to tighten up the rules around eligibility since costs for the program had grown from $6 million to $250 million a year.

The new *Nutritional Supplement Program* will be administered by the Ministry of Health and Long-Term Care instead of the Ministry of Community and Social Services. Many fear the new program will fall far short.

RNAO, the Ontario Disability Support Program Action Coalition, and the 25 in 5 Network for Poverty Reduction have responded by creating five principles that they say should form the basis for the new program. Despite promises that it will be developed in consultation with health, social service, and anti-poverty stakeholders, RNAO still hadn't received details on the consultation process as of late September.

RNAO and its coalition partners have written to Premier McGuinty and Health Minister Deb Matthews about how healthy food is essential for good health; especially for those living with chronic health issues and limited resources.

Recent editorials explain, for instance, that clients who depend on the Special Diet Allowance program are feeling an increasing sense of insecurity and despair, which is creating negative effects on their health.

Almost 1,200 members have also written letters reminding the Premier not to backtrack on his poverty reduction strategy and to keep his promise to consult with health and social services experts on the design and roll-out of the new program.

We'll keep you posted.

Why the numbers count

More than 650 nurses were among those who voiced their disapproval over the federal government's decision to cancel the long-form census and replace it with a voluntary survey.

In a letter to Prime Minister Stephen Harper and Industry Minister Tony Clement, RNAO President David McNeil said the information collected by Statistics Canada is critical for every level of government, civil society, and industry to make evidence-informed decisions. McNeil added the data is particularly vital for those interested in the health and social needs of marginalized people.

The government said it decided to drop the mandatory requirement because it received several complaints about some of the survey's questions.

RNAO was one in a long list of groups to speak out about the decision. There is an overwhelming consensus among over 300 groups, including statisticians, social policy-makers and researchers, that a voluntary survey would produce less reliable data and end up costing more.

The RNAO wants the government to reverse its decision.

RNAO is one of three signatories on a pamphlet that challenges provincial party leaders to place a higher priority on clean, green energy.

Coal must go

RNAO is stepping up its campaign to convince the government to close its coal-fired generating plants now instead of waiting until 2014.

The McGuinty government has pledged to take its four remaining coal plants offline at that time. However, research by the Ontario Clean Air Alliance (OCAA) says as many as 250 deaths a year and tens of thousandsof asthma attacks can be linked to pollution and toxins from the coal plants. By closing the plants now instead of 2014, more than 1,000 lives can be saved.

RNAO is one of three signatories on a pamphlet titled "Coal is costing us the air we breathe." The groups say coal production of electricity should be phased out in favour of greater conservation and by switching to cleaner alternatives. In addition to saving lives and preventing illness, the RNAO, Canadian Association of Physicians for the Environment and OCAA say phasing out coal is the only way the province can meet its obligation to reduce greenhouse gases. The pamphlet challenges all three party leaders to place a higher priority on clean, green energy. **RN**

See "Coal is costing us the air we breathe" at www.rnao.org/coal

CALENDAR

OCTOBER

October 18-20, 2010

KNOWLEDGE, THE POWER OF NURSING CONFERENCE: CELEBRATING BEST PRACTICE GUIDELINES AND CLINICAL LEADERSHIP
Intercontinental Hotel and Metro Toronto Convention Centre
Toronto, Ontario
Register and view the program online: www.rnao.org/events

October 21, 2010

HEALTH INEQUITY: THE STORIES UNCAPPED INTERNATIONAL NURSING INTEREST GROUP BIENNIAL SYMPOSIUM
Mount Sinai Hospital,
8:30 a.m. to 4:00 p.m.
18th floor auditorium
600 University Avenue
Toronto, Ontario
For information: 416-426-7029 or 1-866-433-9695
Email: reg.inig@firststageinc.com or info.inig@gmail.com
Website: inig.rnao.ca

NOVEMBER

November 4-6, 2010

ANNUAL NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO CONFERENCE: THE FUTURE IS NOW
Doubletree by Hilton, Toronto Airport Hotel, 655 Dixon Road
Toronto, Ontario
Register and view the program online:
http://www.rnao.org/npao2010

November 22-26, 2010

DESIGNING AND DELIVERING EFFECTIVE EDUCATION PROGRAMS
89 Chestnut Street, Toronto, Ontario
Register online: www.rnao.org/events

DECEMBER

December 6, 2010

PREVENTION AND MANAGEMENT OF VIOLENCE IN THE WORKPLACE SYMPOSIUM
Windsor Hilton
277 Riverside Drive West
Windsor, Ontario

JANUARY

January 18, 2011

LEADERSHIP FOR NURSES AT THE POINT OF CARE
Workshop available by Ontario Telehealth Network

FEBRUARY

February 3, 2011

12TH ANNUAL QUEEN'S PARK DAY
Queen's Park, Legislative Building/ Delta Chelsea Hotel
Toronto, Ontario

February 4-5, 2011

RNAO BOARD OF DIRECTORS AND ASSEMBLY MEETINGS
RNAO Home Office/ Delta Chelsea Hotel
Toronto, Ontario

February 24, 2011

MID-CAREER NURSING SYMPOSIUM
Location: TBA

Unless otherwise noted, please contact events@rnao.org or call 1-800-268-7199 for more information.

THE NURSING RETENTION FUND

ANNOUNCEMENT: ACCEPTING APPLICATIONS FOR FUNDING

To all public hospitals in the Province of Ontario:

The Nursing Retention Fund (NRF) is designed to provide funds to public hospitals in Ontario for education/training as retention initiatives in circumstances where changes to hospital services may otherwise result in layoffs for nurses.

The NRF is a Ministry of Health and Long-Term Care initiative managed by the Ontario Nurses' Association (ONA), the Registered Nurses' Association of Ontario (RNAO), and the Registered Practical Nurses Association of Ontario (RPNAO).

The fund provides reimbursement to hospitals for the following:
- **cost of education/training required to retain nurses**
- **salary continuance (wages/ salary and benefits) for a period of up to 6 months while nurses are attending education/training programs**

The NRF management committee is pleased to announce the extension of funding available through the fund to 2013. Following discussions between the NRF management committee and the Ministry of Health and Long-Term Care, the funding agreement has been amended to allow for broader eligibility for funding applicants.

Revisions have been made to the application process to provide guidance in the collection of data required to meet the eligibility criteria.

For more information about NRF, as well as application forms, please visit our website: www.nursingretentionfund.ca

You may also contact the NRF Project Coordinator at: 416-907-7954, 1-800-268-7199 x245, or coordinator@nursingretentionfund.ca

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

DID YOU KNOW?

You can access the 'members only' section of the RNAO website to update your e-mail and mailing address. Never miss an issue of Registered Nurse Journal and stay connected with your nursing colleagues across the province. Update your profile today by visiting www.rnao.org/members.

RNAO AT WORK

Speak out for nursing by representing RNAO at work.

BECOME A WORKPLACE LIAISON TODAY!

Visit www.rnao.org/wl or call 1-800-268-7199 to receive regular updates and materials.

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• critically analyzes and applies paradigms to address quality and safety issues in the workplace

Advanced Leadership and Management
(6 units)
• 9 month course completion
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Integrative Leadership Project (3 units)
• Final course integrates theories and concepts of the Program and provide opportunities to apply these to a real situation in the workplace
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Leadership and Management Program
McMaster University
Phone: (905) 525-9140 Ext 22409 Fax: (905) 529-3673
Email mgtprog@mcmaster.ca
Website: www.leadershipandmanagement.ca

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The Nursing Education Initiative (NEI)

NEI is a program funded by the Ontario Ministry of Health and Long-Term Care to provide funding to nurses who have taken courses to increase their knowledge and professional skills to enhance the quality of care and services provided within Ontario.

Applications are available for individual nurses and nurse employers for grants up to a maximum of $1,500 per cycle, per nurse. Please note that funding is not guaranteed.

If requests for funding exceed the budget available, priority will be given to nurse applicants who have incurred the cost themselves.

RNAO Registered Nurses' Association of Ontario / L'Association des infirmières et infirmiers autorisés de l'Ontario
www.rnao.org/nei
educationfunding@rnao.org

RPNAO
www.rpnao.org
nei@rpnao.org

Ontario

RNAO 86th AGM

HILTON TORONTO – FRIDAY, APRIL 8, 2011

CALL FOR RESOLUTIONS

DEADLINE: Monday, December 6, 2010
1700 hours (5:00 p.m.)
For more detailed information, please see page 26 of the July/August RN Journal or visit www.RNAO.org

CALL FOR NOMINATIONS 2011-2013 RNAO BOARD OF DIRECTORS (BOD)

DEADLINE: Monday, December 6, 2010
1700 hours (5:00 p.m.)
In 2011, RNAO is seeking nominees for President-Elect and all 12 Regional Representatives. In addition, there are vacancies on both the Provincial Nominations Committee and the Provincial Resolutions Committee.
Access the nomination form at www.RNAO.org

IF YOU REQUIRE FURTHER INFORMATION, PLEASE CONTACT PENNY LAMANNA, RNAO BOARD AFFAIRS COORDINATOR, AT PLAMANNA@RNAO.ORG

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Our recruitment continues in order to meet needs for our capacity-building initiatives. In 2011, the 17,500 square metre **Surrey Outpatient Care & Surgery Centre** will open and provide a unique combination of day surgery, medical tests & procedures, and specialized health clinics in a modern care setting. The **Critical Care Tower** at Surrey Memorial Hospital, set for completion in 2014, will increase the hospital to 650 beds and will include in part, a dedicated regional Perinatal Centre, new Emergency Department, helipad, and expanded ICU.

Fraser Health has current needs for NICU, Critical Care and Emergency Registered Nurses for various locations. **Successful candidates are eligible for relocation assistance of up to $5,000.** We also offer a comprehensive benefits package that includes four weeks vacation after one year, family extended health and dental coverage, and a defined-benefit pension plan. Contact us today!

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Correspondence Course –
RNAO member discount 30%
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NAPCC patient website: www.napcc.ca.
Education program website:
www.cpccprogram.com
Email: napcc@cogeco.ca
Telephone: (905) 560-8344

TB: WHAT WE KNOW... AND WHAT LIES BELOW

November 15 & 16, 2010, Delta Chelsea Hotel, Toronto, Ontario. An initiative of the Tuberculosis Committee, The Lung Association.

For more information please visit www.on.lung.ca/tbconf or email registration@eventives.ca.

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L'Association des infirmières et infirmiers autorisés de l'Ontario

Prevention & Management of Violence in the Workplace Symposium

December 6, 2010
Windsor Hilton, Windsor, Ontario

Symposium Objectives:

Discuss Healthy Work Environments and highlight the RNAO Guideline: *Prevention & Management of Violence in the Workplace*

Identify differences between interpersonal conflicts & harassment

Study the profile of workplace bully and workplace target

Provide tools to create a violence-free workplace

events@rnao.org / www.rnao.org/events

BY LARISSA N. BENEY

ILLUSTRATION: JOSE ORTEGA

What nursing means to me…

When someone asks me "what is a nurse?" or "what do nurses do exactly?" I often stumble over my words. I give some vague answer that does not do my profession justice. In my head, I think, "How can words describe the complexity of this beloved and trusted profession?" If only they could experience what my day at work is like. If only they could see how my job is more than following doctor's orders, giving medications, or changing beds. If only they could hear what goes through my head when I'm recording a child's high temperature or analyzing blood work. If only they could see that the health of an individual is so much more than treating a disease. If only they could understand the difference taking the time to sit with a patient can make.

DROP US A LINE OR TWO
We'd love to hear about what nursing means to you. Your story could appear in *RN Journal*. Email editor@rnao.org.

On my second day of work as a new grad I had a one-year-old patient whose diagnosis was uncertain. This dear child had been poked and prodded time after time and the doctors were still trying to understand what was going on. It was obvious that the mother was concerned and cared deeply for her child, but each time I went in to check on the newborn, she was by herself sitting in her crib. The health-care team had been in and out all day taking blood, doing assessments, taking a swab for this and a swab for that. Each time the baby saw one of us approach in our yellow gowns and masks she would get restless and fussy.

During that afternoon when I went in to do my hourly check she was alone again, sitting in her crib looking around. I approached the crib and smiled through the mask and started rubbing her back. She looked at me with her big brown eyes and raised her arms. To my astonishment, I realized this dear child likely had not been cuddled or hugged much at all that day. I picked her up and she clung to me with a fierce little grip, and laid her head on my shoulder. She would not let go. I will never forget the feeling of this little one hugging me so.

I was humbled that I was able to be there for her in this way. At that moment, I realized that this is what nursing means. These precious, comforting moments flicker by us so quickly, and often go unnoticed, but they are the foundation of everything nurses do. **RN**

Larissa N. Beney, RN, BScN, works in hematology/oncology/medicine at McMaster Children's Hospital in Hamilton.

InterChurch Health Ministries Canada

Parish Nursing Ministry Information Forum

Who should attend?
Registered Nurses, Congregational Members, Clergy, those interested in health and healing ministry

Tuesday, October 19, 2010
7:00PM to 9:00PM
(Registration starts at 6:30PM)
Lutheran Church of Our Saviour
368 10th Street, Owen Sound, ON
N4K 1S6

Please call ICHM Canada at 1-888-433-9422 to reserve your seat.

There is no cost for registration

Registered Nurses Working With Faith Communities

Are you curious about Parish Nursing Ministry?

We will offer an Information Forum for your congregation!
Please call to reserve your date.
Please call 1-888-433-9422, visit our website at www.ichm.ca or email info@ichm.ca

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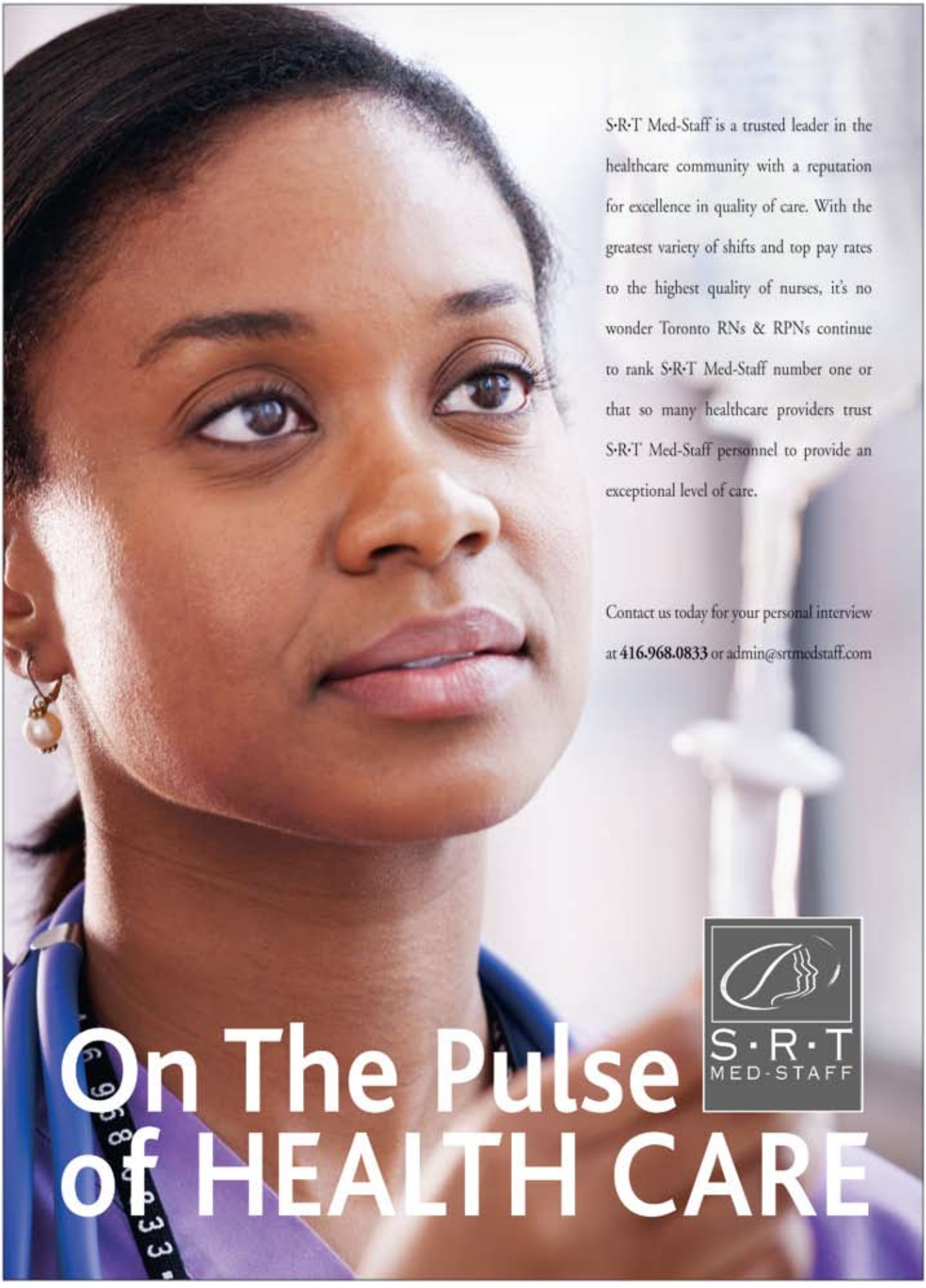
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