Beginning in 2013, RNAO members will be able to play a more integral role in deciding important governance issues that impact the current and future direction of the association. With the introduction of legislation governing the operations of not-for-profit organizations in Ontario, RNAO’s bylaws have changed and members (‘associates’ and ‘friends of RNAO’ excluded) will now have the opportunity to vote electronically on issues such as the selection of the association’s auditors, who gets to sit on the board of directors, fee increases (for more on the proposed fee increase, see pg. 7), and more. Previously, members chose ‘voting delegates’ to represent their views at the annual general meeting (AGM) in April, and to vote on matters on behalf of their chapter, region without chapters, or interest group.

Bill 65, the Not-for-Profit Corporations Act, received royal assent in the legislative assembly in October 2010, but Ontario’s 46,000 not-for-profit corporations – RNAO among them – were given three years to fully implement changes. The government says the revised legislation is meant to: give more rights to members; enhance corporate governance and accountability; simplify the incorporation process; and better protect directors and officers from personal liability.

“This legislative change is an important one for our members because it means they can have a direct say on any number of issues that impact directly on the work nurses do for Ontarians and the work RNAO does on behalf of nurses,” says Sara Lankshear, RNAO’s Region 3 representative on the board of directors, and chair of the bylaws committee. “It’s a really great opportunity for RNs to influence what happens in our professional association.”

So, what exactly does this mean for the average member?

Put simply, the annual meeting will be structured differently this April, and in the years ahead. It will be broken into two sessions: the ‘governance/business’ session will take place in the morning, and the ‘membership consultation’ session will take place in the afternoon. The results of membership voting on the auditors, board of directors, and proposed membership fee increase will be announced during the governance/business session. The president and CEO will also provide their annual reports in the morning. By mid-day, the formal AGM will be declared closed and the membership consultation session will begin.

Those individuals chosen by their chapter, region without chapters, or interest group to represent the views of their colleagues will participate as ‘representatives’ (formerly known as voting delegates) during the afternoon session. Representatives will consult with fellow members in advance of the AGM, and will attend the event in anticipation of the opportunity to debate the issues, ensuring their endorsement (or lack thereof) is reflective of the feedback they’ve received from colleagues in the community. Determination of the number of representatives for each chapter, region without chapters and interest group remains unchanged, and will be based on the same criteria as that used to determine voting delegates in the past.

“It’s far more democratic to allow each one of our individual members to weigh in on matters regarding the governance and direction of the association,” says President Rhonda Seidman-Carlson. “What better way to provide nurses with more ownership of their professional association, and more stake in the strategic direction it chooses to pursue.”

For more information on the issues that require a vote, and the process for casting a ballot, visit www.RNAO.ca/AGM2013. RN

Refer to page 26 for details on the call for representatives and registration for the AGM.

Kimberley Kearsey is Managing Editor at RNAO.
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Adversity feeds perseverance, strength

It’s estimated there are more than 200 types of cancer (pg 18). Few people can say their lives are untouched by this disease, and nurses are no exception. In this issue, four RNs share their perspectives on an illness that is expected to change the lives of more than 185,000 people this year alone. I have a great deal of respect for nurses. And oncology is one of those specialty areas that I can’t help but stand in awe of. There are likely hundreds of untold stories of RNs doing amazing things in cancer care across the province. The four we bring you in this issue offer a glimpse of the important work that’s going on. But we want to bring you more. If you are an oncology nurse, please share your story with editor@RNAO.ca.

Nurses in primary care are also featured in this issue. We speak to several RNs who want to do more for their clients, but find they are not able to practise to their full scope (pg 12). RNAO is calling on primary care organizations to enhance access to the system. Nurses in this specialty have the skills and knowledge to do more, and they want the opportunity to make a greater difference to the people who turn to them for help.

That notion of making a difference was at the core of a fundraiser I was privileged to attend on Nov. 7. It was a benefit concert for the Stephen Lewis Foundation, an organization that works with community groups in Africa to support women, orphaned children, grandmothers and people living with HIV and AIDS. The importance of this work is unmistakable when you consider 14.8 million African children under the age of 18 have been orphaned because of HIV and AIDS. Hope Rising was created to shine a spotlight on African women who are overcoming adversity in an effort to turn the tide on this pandemic. In many countries throughout southern Africa, it is estimated that between 40 and 60 per cent of orphans live in households headed by grandmothers. Inspiring performances by African women and girls, who travelled thousands of kilometres to take part in the event, revealed a remarkable strength that was contagious that night. Adversity does that, doesn’t it? Feeds perseverance and fosters strength.

Whether we come face-to-face with HIV/AIDS or cancer, or find ourselves fighting for a greater sense of worth at work; there’s nothing like a dose of adversity to push us to the top of our game. Here’s to the new year ahead, and lots of game-changing moments for our members.
PRÉSIDENT’S VIEW WITH RHONDA SEIDMAN-CARLSON

Bullying is alive and well in nursing

This fall, the terrible issue of bullying was front and centre once again. The story of Amanda Todd and her cry for help, and subsequent death, were difficult for me to bear. There is no doubt this girl suffered from depression, but the taunting, ridicule and isolation she experienced is something no one should have to endure. In response to this tragic event, schools throughout the province held vigils and assemblies to talk about bullying, its impact, its causes and how to stop it. It is important to hear the messages being shared with our youth: do not be silent when you know someone is being bullied, and; just because someone is ‘different’ does not give another person the right to bully them. These same messages have been echoed across Canada.

Why am I writing about bullying? I believe nurses – if placed in the school system and supported to use their full knowledge and ability – could make a tremendous contribution to everyday student life by helping and supporting children and adolescents at a tender time in their lives. But that is not why I am writing this column. The truth is bullying is alive and well within our profession and we know it. And that makes me very angry and very sad.

At our board and assembly meetings in September, we heard about instances of bullying between registered nursing students and registered practical nursing students at educational facilities. We also heard about nursing students being bullied during clinical placements. I’ve heard people discuss the bullying that goes on between members of staff in various health-care organizations. Why is this continuing to happen?

There are lots of theories about what causes bullying in these three scenarios. They amounts to condoning the very act we find abhorrent. Staying silent includes us in the group of bullies. Most organizations have a code of conduct and a whistleblower process so that one can identify bullying to an external source. RNAO’s BPG, Preventing and Managing Violence in the Workplace, includes recommendations on how to identify and address violence, including bullying.

“STAYING SILENT AMOUNTS TO CONDONDING THE VERY ACT WE FIND ABHORRENT. STAYING SILENT INCLUDES US IN THE GROUP OF BULLIES.”

However, there is one simple intervention. Identify what you see and hear as bullying and insist that it stop. Speak with your teacher, manager or VP until someone listens. Do not engage in the gossiping about a colleague (a subtle form of bullying) and clearly state that you will not allow bullying to go on. This is a shared responsibility.

Many of Amanda’s classmates regret staying silent. They will have to live with that regret for the rest of their lives. While I have not heard of a nurse who was bullied and resorted to suicide, I have heard of nurses who were bullied and left their workplace or the profession altogether as a result. We cannot afford to let this happen. The decision to confront – and the responsibility to report – lies with each of us.

I recently had the privilege to hear Dr. Izzeldin Abuelaish speak at a community event. He grew up in the Javalia refugee camp in Gaza and eventually obtained his medical degree. He is a religious and committed family man. In 2006, he lost his three daughters and a niece in a shelling incident. Rather than hate or accuse, he has used this tragic event as a driver for peace. He tells everyone he meets: “Hate is not a response to war.” Each person can and needs to make a difference towards peace, he says. The peace he talks about is not only limited to the Middle East but, in each family, each workplace and each community.

As president of RNAO, I urge you to bring this message back to your workplace, whether a university or college environment or a health-care facility. This is an issue we must deal with head on. Bullying is a type of war on the soul. Please do not respond to bullying with more bullying, and please do not respond to fear, frustration and self esteem concerns with bullying.

I am urging each one of us to not be silent anymore. RN

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

Find out more about RNAO’s BPG at www.RNAO.ca/violencebpg
Visionary Leadership: Charting a Course for the Future of Nursing

A year ago, RNAO’s board of directors (BOD) grappled with a troubling trend: Ontario’s registered nurses were being replaced. In its wisdom, the board decided to take a stand not only on the replacement of RNs, but also on the role of all nurses in our health system. As trendsetters for nursing in Ontario and beyond, the BOD and senior staff began work on what would become our future vision for nursing and the health system in Ontario: a vision that involves foundational system transformation, and at the same time enriches the role and practice of nurses to better serve the public.

This initiative is now in full swing, and RNAO is calling on you – our members – to help reclaim and re-imagine the role of nurses as champions of health promotion, disease prevention and curative care; as knowledgeable and experienced partners in evidence-based and cost effective health-care delivery; and as leaders and strong advocates for social and health equity.

Let me take you to the beginning of our journey for a sense of how our vision emerged.

Mirroring the approach taken by the International Council of Nurses to build preferred futures for the profession, RNAO senior policy analyst Lynn Anne Mulrooney led in the creation of three scenarios (or alternative images) for the future of nursing: business as usual, crisis and opportunity and visionary leadership. These three alternative futures are possible and credible snapshots of the year 2030. All three were brought forward to the BOD, and after robust discussions, visionary leadership was unanimously chosen as the most suitable scenario. Together we have since mapped a step-by-step path to our vision for the future of nursing in Ontario.

We now have a picture of primary health care as close to home as possible, through community governed interprofessional and intersectoral teams, tightly linked to public health. Hospitals have become more important than ever because, as part of their local health networks, they attend to only the very sick, as more and more care has been moved to the community thanks to universal access to home health care and pharmacare. Nurses in 2030 play a central role in the planning and delivery of health services, thanks to NPs’ and RNs’ expanded practice scopes.

“NURSES IN 2030 PLAY A CENTRAL ROLE IN THE PLANNING AND DELIVERY OF HEALTH SERVICES, THANKS TO NPS’ AND RN’S EXPANDED PRACTICE SCOPES.”

where visionary leadership will take us. This picture of nursing in 2030 is very different from what we see today. Imagine a system where push-back from nurses and the public in defense of democratic and social rights, enabled by social media and ongoing economic instability, has left politicians in 2030 with no choice but to implement a ‘health in all policies’ approach that requires every government decision be assessed for its impact on population health. The decade-long action by RNAO that began in 2012 with the release of two seminal reports on community care (Primary Solutions for Primary Care and Enhancing Community Care for Ontarians (ECCO)) has resulted in a system that, in 2030, is anchored in comprehensive agreements – and our own governments’ policies at the national and jurisdictional levels – have been refashioned, no longer representing a threat to our publicly funded, not-for-profit health system.

It’s a promising future and one that is entirely feasible with the focused and purposeful action of RNAO and its members.

But enough about the future we all hope to see. Let’s get back to what we need from you today to make this happen.

RNAO has begun hosting electronic town hall meetings, informal discussions, and focus groups to receive feedback on this vision from nurses across the province. This consultation will complete the exercise our BOD began a year ago. Ultimately, we will have a clear vision of what is needed to ensure nurses can fully contribute their current and future competencies and expertise so the public gets the timely access and quality of care it needs and deserves. This consultation with members will enrich the vision, and is at the centre of our massive undertaking.

The BOD and RNAO staff cannot wait to hear your feedback, and we know that as we move forward, we will inspire one another to make this vision a reality. RN

DORIS GRINSPUN, RN, MSN, PhD, LD(hon), O.ont, IS CHIEF EXECUTIVE OFFICER OF RNAO.
Building on RNAO’s success

Members asked to approve first RNAO fee increase in 14 years.

BY KIMBERLEY KEARSEY

IN advance of RNAO’s 2013 annual general meeting in April, members will be asked to vote on a membership fee increase of eight per cent. RNAO has not raised its membership fee for 14 years, and the board of directors is asking members to support the much-needed boost.

Given the association’s tremendous growth in members, influence and impact over the past 15 years, this increase will help the association to maintain the high level of excellence for which it has become well known. It will also ensure more than 35,000 RNs and nursing students continue to receive bang for their membership buck.

In 1999, there were 14,699 members. By the end of the 2012 membership year, 35,012 nurses and nursing students either joined or renewed. With a membership base that has more than doubled, and with the growing demand for enhanced services and programs, the board of directors is unanimous in its support for the increase.

“RNAO is a tremendously successful organization that has been able to generate sources of revenue and create efficiencies that have offset the need for a fee increase for 14 years,” says President Rhonda Seidman-Carlson. What other organization can claim such an accomplishment? “RNAO’s ability to diversify and bring revenues through consulting services and centre packages, the RN Careers job board, educational programs such as institutes and workshops, affinity partnerships, and more, is commendable,” she says. “Nonetheless, the reality is that we’ve reached a crossroads, and our costs now exceed the actual fee charged to members. Without the increase, RNAO will not be able to offer the same level of services and programs it has in the past.”

Seidman-Carlson adds. “We must recognize that there has been an increase in the consumer price index of 30.5 per cent since 1999. And as the salary of an RN has increased, the percentage of the RNAO fee to salary has substantively decreased.”

If approved by members, the fee increase would mean a difference of between $2 and $23 per year, depending on the membership fee category.* For instance, membership in the regular fee category will increase from $285 to $308. Members in the ONA category will pay $227, up from $210. And the fee in the undergraduate nursing student (UNS) category will go from $20 to $21.60. With all 12 fee categories expected to change in varying degrees, Grinspun says the increase will support stability, and will “ensure RNAO remains a strong and vibrant professional association.”

One benefit of RNAO membership is automatic membership with the Canadian Nurses Association (CNA) and Canadian Nurses Protective Society (CNPS). Over the past 14 years, and without impact on its members, RNAO has absorbed fee increases of 100 per cent for CNA (from $27 in 1999 to $54.95 in 2013) and 44 per cent for CNPS (from $11.25 in 1999 to $16.25 in 2013).

“RNAO was a very different organization when it passed the last fee increase in 1999,” says CEO Doris Grinspun, who has led the organization since 1996. “Members, board and staff should be extremely proud of RNAO and its members’ influence and impact locally, nationally and internationally. This is thanks to our collective visionary leadership and expert work, anchored in robust values and an unwavering commitment to improving the lives of nurses, patients, and our province. We can only advance this type of outstanding work with the active support of members, whether intellectual or monetary.”

“Had membership fees kept pace with inflation, a regular membership today would be $372 annually instead of the current $285,” Grinspun adds. “To find out more about the board’s position on the proposed change, visit www.RNAO.ca/feeincrease

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*All fees include HST

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Kimberley Kearsey is managing editor at RNAO.
RNAO & RNs WEIGH IN ON...

NURSING IN THE NEWS

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Disaster management in Peterborough

There was organized chaos at Peterborough Regional Health Centre on Oct. 16. A staged bus crash with 15 victims, played by Fleming College students, arrived in the emergency department with simulated critical injuries to assess the effectiveness of the hospital’s existing emergency plans. ER manager Colleen Armstrong says the experience was “valuable,” adding “this (mock disaster) gives staff the chance to get involved. We want to hear from them about how this went.” Working in collaboration with Peterborough EMS and the Fleming College Emergency Management program, staff tested their Code Orange plans, playing out the logistics of how to move around existing patients in the emergency department to make way for victims with critical injuries. “The Code Orange plans implemented during the mock disaster, this is the base for the plan to deal with more extreme circumstances,” says Armstrong. “I’m hoping to get a lot of learning out of this.” (Peterborough This Week, Oct. 16)

Colleen Armstrong leads colleagues through a mock disaster to test emergency preparedness at Peterborough Regional Health Centre.

RNAO president explains phase out of CCACs

RNAO President Rhonda Seidman-Carlson openly praised the recommendations in the association’s Enhancing Community Care for Ontarians (ECCO) report, published in early October (see pg. 24 for further detail). The comprehensive document recommends that Ontario’s 14 Community Care Access Centre (CCAC) functions be phased out and 3,500 personnel (most of them RNs) move to existing primary care organizations over a three-year period. Primary care is a “health sector that knows its patients most intimately,” says Seidman-Carlson. “Care coordination and system navigation is anchored best within primary care.” The report proposes a temporary Primary Care Transitional Secretariat be set up within each Local Health Integration Network (LHIN) until the model is fully functional. In response to the report, some CCACs say this “is not a workable policy proposal.” However, Seidman-Carlson says “implementing the recommendations means primary care providers will be the ones ordering home care and support services, linking and following-up with specialists, and facilitating people’s transitions from their homes to nursing homes.” (Canadian Healthcare Network, Oct. 11)

Perceptions of male nursing

David Mastrangelo (right) is an RN who has worked for 10 years in a profession that is predominantly female. Throughout a nursing career that has spanned the sectors of acute care, public health and long-term care, Mastrangelo has aimed to improve the image of men in nursing. He is the interim president of RNAO’s Men in Nursing Interest Group. In that role, he recently spoke with CBC Toronto’s Metro Morning about the gender-based stereotypes the public has about nursing. He says the limited number of men working in the profession may be linked to the fact that people simply don’t know what nursing entails. The media play a role in generating misconceptions, he says. “We don’t have many images of male nursing in the media, but overall we’re moving forward,” he told CBC’s Matt
Galloway. When Mastrangelo started his career, three per cent of RNs were men. Today, that figure is five per cent. “Luck,” he says, played a large part in how he fell into nursing. “I wanted to be a paramedic,” he recalls thinking before an interview for a hospital placement. His interviewer suggested he go into nursing, and he says he’s had countless “a-ha-moments” since. (Oct. 19)

Retired RN celebrates several decades of helping HIV/AIDS patients
This fall, the AIDS Committee of Cambridge, Kitchener, Waterloo and area (ACCKWA) celebrated its 25th anniversary. The committee planned a year of anniversary events, and retired public health nurse Dianne Roedding was on hand at several to offer support. Two decades ago, Roedding was hired to educate people about a virus that few understood. She recalls the emergence of AIDS in the Waterloo region in the late 80s, saying: “Back then, people thought AIDS was confined to people in the ‘five H’ categories — hemophiliacs, hookers, homosexuals, Haitians and heroin addicts.” Today, there is a much better understanding of the virus thanks to events such as World AIDS Day. ACCKWA formed in 1987, and Roedding began working for the region’s public health AIDS program in 1988. It was a time when stigma was pervasive, and treatment non-existent. “(People with HIV/AIDS) were facing rejection from family, from community and from faith organizations,” she says. “So we had to build that support.” (Kitchener Post, Oct. 4)

School nurse comforts Afghan teen
Tui Noonan, a school nurse at Ottawa’s Ashbury College, treats students’ ailments with both medication and sensitivity. The latter was certainly a necessity working with Roya Shams, a young refugee from Afghanistan who struggled to fit into a new culture when she arrived in Canada in January 2012. “I felt for her,” says Noonan, the wife of a diplomat who says she knows what it’s like to feel like an outsider. “She would often come up here (the school dispensary) and have a chat. She’d talk about her family (who still live in Afghanistan). She was worried about them. Her mom’s got a cardiac condition. She was so tired often when she came to school because she was up in the middle of the night calling home.” Roya fled her war-torn country after her father, an Afghan police commander, was killed by insurgents. Before his death, he encouraged Roya to brave Taliban threats and go to school in Kandahar so she could later help fight for equal rights. Thanks to support from Noonan, and from her teachers, tutors, friends and a growing extended family in Canada, Roya has come out of her shell since her arrival almost a year ago, and has even spoken at a school assembly about life in Afghanistan. (Toronto Star, Oct. 26)

Guarding against the flu virus
As flu season ramps up once again, Brantford RN Ruth Gratton feels positive about the crowds of people who turned up for their free flu shot at the Brant County Health Unit’s (BCHU) first clinic in mid-October.

“People are usually so thankful for the clinics,” the BCHU manager of infectious diseases says. “There is rarely a wait.” Getting the shot this year is extra easy because pharmacists are now permitted to administer the shots. Gratton warns that the nature of the flu virus is unpredictable and it’s a lethal danger to some, especially the elderly. She advises that everyone should get vaccinated every year to protect themselves and their families from the virus. “The burden of illness is horrendous,” she says. “Everyone is susceptible to it.” (The Brantford Expositor, Oct. 17)

And in other flu news...
Twenty-nine long-term care homes in the Simcoe-Muskoka region were recognized at an awards ceremony in October for participating in a challenge issued by the district health unit to increase the number of healthcare workers getting their flu shots. Mandy Deeves, the coordinator for the Regional Infection Control Network of North Simcoe Muskoka, says: “This
event provides an opportunity to highlight and recognize the commitment our health-care facilities have to their staff and community by supporting immunization.” This is the second annual Simcoe Muskoka Influenza Immunization Challenge. Two area hospitals received honourable mentions at the ceremony for boosting their staff immunization rates by 10 per cent over last year. Generally, the immunization rate among health-care workers in Simcoe Muskoka is almost 10 per cent above the provincial average of 60 per cent. (Stayner Sun, Oct. 9)

Deceased homeless remembered

Abe Oudshoorn, assistant professor at Western University’s School of Nursing, and founder of the London Homelessness Outreach Network, calls the planned creation of a homeless memorial a “statement.” It’s a fitting tribute to those who deserve to be properly acknowledged, he says. When a local homeless person dies, the social agency that has worked closely with the individual may stage a service. If next-of-kin is not found, and the homeless person does not have any money, the city arranges for burial. Usually, there isn’t a funeral service or grave marker. “Everyone has value. But sometimes, there’s no one to tell that story,” says Oudshoorn. The committee raised about $9,000 of the necessary $15,000 to build a memorial, appearing as a rock and plaque in one of London’s parks. The memorial will give people a physical site to mourn the passing of a friend or kin, he says. (The London Free Press, Oct. 22)

Wingham chemo clinic marks its 10th anniversary

A decade after opening its doors to thousands of cancer patients, the chemotherapy unit at Wingham and District Hospital threw a luncheon to mark the milestone. The 10th anniversary ceremony in October highlighted the achievements of cancer survivors and clinic staff over the past decade. RN Linda Wall was the unit’s first nurse. Wall, a former retiree who returned to work to ensure chemo patients receive essential care, says she’s “…very proud of this moment, to be able to provide this service to the community.” Operating as a satellite site to the South West Regional Cancer Program, the Wingham oncology program has been open since November 2002, and is appreciated by patients who now receive care closer to home. Several Wingham-area cancer survivors were present to mark the anniversary. “The patients are the heart and soul of this program,” says Wall. (Wingham Advance-Times, Oct. 24)
NURSING NOTES

Dvd helps health professionals care for elderly with diabetes
The Canadian Diabetes Association (CDA) recently recognized a group of diabetes educators, including RNAO long-term care best practice co-ordinator Heather Woodbeck (right), for developing a DVD that helps health professionals caring for seniors with diabetes in long-term care. The Seniors Health Knowledge Network together an interdisciplinary team to provide short term, intensive case management. The centre opened in September and is expected to be fully operational by January. It "works with patients to identify issues that may interfere with their ability to manage their diabetes," Crawford says, noting the group will provide services for the roughly 15 per cent of patients who become unstable because of related health issues such as kidney function, high blood pressure and heart disease, as well as psychosocial and economic barriers. Crawford says: “The goal is to help these patients to make incremental but meaningful changes that, over time, improve their health and quality of life.”

New CCDC helps patients with complex diabetes
RNAO member Trish Crawford has taken on the role of interim director for Peterborough’s new Centre for Complex Diabetes Care (CCDC), one of only six such centres in Ontario. Housed at Peterborough Regional Health Centre, the CCDC brings

Being HIV positive does not equate to being a criminal
The Supreme Court of Canada absolved HIV carriers of the legal obligation to inform sex partners about their condition as long as they have a low level of the virus and wear a condom. RNAO adopted this view in early 2012, endorsing the Toronto Day of Action against the Criminalization of HIV. The association’s stance is that with anti-retrovirals and condoms, being HIV positive does not necessarily mean someone poses significant risk to a sexual partner and should be considered a “criminal.” The court ruled 14 years ago that people with HIV must inform their sex partners of their condition, or face a charge of aggravated sexual assault, which carries a maximum life sentence. On Oct. 5, that duty to disclose was removed.

Canada first for home care giant, SEHC
Saint Elizabeth Health Care (SEHC) was recognized this fall by Excellence Canada with its highest level of achievement, the Canada Order of Excellence Award. It is the first home and community care service provider to earn the ranking. The country’s governor general hands out the award to organizations that have met or exceeded criteria related to leadership, planning, programs, customer/client focus, people engagement, process management and partner relations.

“Home and community care has an increasingly critical role to play within our health system as the country continues to experience changes in demographics, technology and knowledge exchange,” says Shirlee Sharkey, former RNAO president and SEHC president and CEO (left). “This award validates the approach we take to always look beyond ourselves.”

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

Diabetes Community of Practice (SHKN Diabetes CoP) received the CDA Diabetes Resource Award in October, along with $750. Nurses represent one professional group on the SHKN Diabetes CoP, and Woodbeck is a founding member. She continues to raise awareness of Diabetes 101, which she describes as a “...truly collaborative project.” The SHKN Diabetes CoP launched a monthly webcast series (based on the DVD) in September. To find out more, visit www.seniorshealthknowledge network.com

In memoriam
RNAO extends its deepest condolences to family and friends of

Ethel Meade, an activist and advocate on health-care issues, and one of the founding members of the Ontario Health Coalition. Meade was an instrumental member of Ontario’s Elder Health Coalition, which was set up to bring together 40 provincial organizations (RNAO included) to help create and shape healthy public policy for older persons. She passed away Oct. 10, just four days shy of her 93rd birthday.
Primary care nurses have the skills – and desire – to provide more comprehensive care that will benefit patients.

BY MELISSA DI COSTANZO
Kathleen Boyd is a primary care RN at Southlake Regional Health Centre.
Three years ago, Newmarket RN Kathleen Boyd started working on the family health team (FHT) at Southlake Regional Health Centre. She was the team’s first RN, and wanted to gain more insight into the role of a primary care nurse by visiting other FHTs that already had an RN on board. She was surprised by what she found. Boyd expected to see nurses practising autonomously in roles that demand their expertise. Instead, she saw RNs spending most of their day administering needles, triaging patients by phone, taking blood pressure, and recording heights and weights. “It was very discouraging,” she recalls. “I was not expecting to see fully trained RNs working in the capacity of an RPN or administrative staff.”

Boyd’s concern was that these nurses were not practising to full scope. They were not performing physicals or leading health counseling appointments with patients. These nurses, she says, may not have understood the extent of their scope of practice.

“We are autonomous professionals who can work on our own appointments and see patients separately from the doctors,” Boyd says, noting that for the sake of the profession and patients, “it’s important...for us to develop our knowledge and use it.”

After three visits to other FHTs over a three-week period, Boyd returned to Southlake, determined to work to her full scope. As her role developed, she began to take on quarterly diabetes visits. As she became more comfortable, she began doing well-baby visits, pre-operative assessments, and cognitive assessments for the elderly. “I took it step-by-step, (and) tried to identify where the gaps in care were, and where (I) could take some of the workload off the doctors.”

The response was mixed, she admits. Half of the physicians on the team embraced her contribution. Others did not. At times, Boyd says she would be in the middle of a diabetes assessment or counseling with a patient, and would be asked to administer a shot to a baby or call a patient with their x-ray results. It was disruptive to the therapeutic relationships she was developing with her patients, and didn’t take into account her desire and capacity to work independently.

Boyd politely – but firmly – talked to her physician colleagues. That conversation made all the difference in the world, she says. Now, they have a better sense of her professional capacity.

It’s intimidating to initiate that kind of conversation, but Boyd recommends any RN who isn’t practising to full scope, but would like to – and has the knowledge and skills – express themselves. “They are realizing how much we can do...and the power of a nurse,” she says of most physicians.

This increased awareness can be linked, in part, to the spotlight RNAO is shining on primary care nursing and the vast knowledge and clinical skill these nurses bring to community health centres, nurse practitioner-led clinics (NPLCs), FHTs, and other family practice settings. There are almost 4,300 primary care nurses (over 2,800 RNs and 1,400 RPNs) working in Ontario. However, the unfortunate truth is that thousands across Canada are not practising to their full scope. Nationally, it’s estimated only 61 per cent of nurses who practise in primary care are actually doing what they’ve been trained to do despite being ready, eager and willing to take on additional responsibilities.

February 2012, RNAO launched the Primary Care Nursing Task Force, charged with responding to this issue. In June, the task force – comprised of a number of partners including the Association of Ontario Health Centres, the Association of Family Health Teams of Ontario, the Ontario Medical Association and RNAO interest group Ontario Family Practice Nurses – released a groundbreaking report called Primary Solutions for Primary Care: Maximizing and Expanding the Role of the Primary Care Nurse in Ontario. The report’s 20 recommendations are targeted towards three main outcomes: improving timely access to quality primary care in the province; system integration and effectiveness; and cost savings for both the government and taxpayers. RNAO
The goal of every primary care organization must be to reach the highest current level of scope of practice (right) by the end of 2013.

Enhancing the role of primary care RN

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<tr>
<th>Leads holistic assessments</th>
<th>Leads and interprets comprehensive holistic assessments</th>
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<tr>
<td>Implements nursing interventions based on direction</td>
<td>Identifies, plans and prioritizes nursing interventions</td>
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<td>Supports care plan with interprofessional team</td>
<td>Develops, implements and refines care plan with team</td>
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<td>Provides clinical services</td>
<td>Provides in-person and telephone counseling, triage and follow-up</td>
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<td>Supports chronic disease management</td>
<td>Acts as an evidence-based champion in delivering care</td>
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<td>Supports operation of clinic</td>
<td>Assists patients navigating through the health-care system</td>
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<td>Provides patient education</td>
<td>Provides comprehensive clinical procedures, health screening, and treatment</td>
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<td>Record presenting concern</td>
<td>Leads chronic disease prevention, management and self-care</td>
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<td>Prepare exam rooms</td>
<td>Leads community analysis and planning</td>
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<td>Clinic operation</td>
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sees this as the first step towards maximizing the role of all health professionals.

The report categorizes its recommendations in two phases. Phase 1 is geared towards ensuring the adoption of new role descriptions for RNs and RPNs – descriptions that were developed as a resource for primary care organizations to promote full scope of practice. These descriptions, which include key elements of practice taken from existing primary care nurse roles across Ontario, will maximize the role.

Recommendations for this first phase are targeted towards the Ministry of Health, RNAO, Local Health Integration Networks, and primary care organizations. They include: appointing a government committee that will convene for six months to ensure the suggestions in the report are implemented; designating a nurse lead at primary care organizations; and supporting primary care nurses to practise to full scope within interprofessional teams. All of the recommendations in Phase 1 have immediate deadlines.

The recommendations for implementation in the second phase were developed in an effort to expand the role of primary care nurses. They focus on amendments to key pieces of legislation, including authorizing RNs – within their level of competency, knowledge and skill – to prescribe, compound and sell medication, order diagnostic imaging, and communicate a diagnosis. The task force also wants to see support for RPNs in executing clinical and educational programs that focus on health promotion and disease prevention; and support and funding strategies that allow at least 70 per cent of primary care nurses to work full time. Deadlines for the second phase span from 2013 to 2015.

Once implemented, these recommendations are expected to stretch beyond the primary care sector. Long-term care and home care will also reap positive spinoff,” says RNAO CEO Doris Grinspun, co-chair of the task force. “This report will produce whole system change,” she says. “We focused on primary care initially because that’s where patients first have access to the system, and that’s where system change should begin. But it will extend way beyond that.”

The Association of Ontario Health Centres (AOHC) shares this view. In fact, the association’s 73 community health centres, 10 aboriginal health access centres and 15 community FHTs share a common goal: to ensure all health providers work to their full scope of practice within three years, says Executive Director Adrianna Tetley. Many CHCs, she adds, do use RNs and RPNs to full scope and most of the others are committed to getting there.

Tetley says the task force report is a pivotal first step in transforming Ontario’s primary care landscape because it clearly defines the roles of the RN and RPN in this sector.

Distinguishing these roles will have implications on other health-care professionals such as dietitians and pharmacists, she adds. “Their roles are going to shift (when nurses are working to full scope),” she says. RNAO’s report “becomes a starting point to have that conversation.”

Judie Surridge, president of RNAO’s Ontario Family Practice Nurses (OFPN) interest group, and a family practice RN at Toronto’s Women’s College Hospital, co-chaired the task force alongside Grinspun. She thinks one of the key reasons primary care nurses are not working to full scope is because health-care professionals – nurses included – are not fully aware of the spectrum of care RNs and RPNs can provide. RNs have valuable expertise in chronic disease management, health promotion and disease prevention. This is in addition to traditional skills such as administering needles and taking a patient’s blood pressure.
Funding models for primary care can also create a barrier to nurses’ scope of practice. Currently, physicians are compensated when they carry out duties that can fall into primary care nurses’ capabilities, such as assessments. This means nurses’ responsibilities are often determined by the doctor, explains Nicole Nitti, a family physician and medical director at Toronto’s Access Alliance Multicultural Health and Community Services.

She thinks nurses can help speed up patients’ access to primary care by taking certain responsibilities off physicians’ plates. A diabetes assessment is one example. “Nurses practise nursing and doctors practise medicine,” Nitti says. “There is significant overlap (between the roles), which is nothing to be afraid of, but the thing to remember is that nurses bring a whole other piece that has been under-emphasized in primary care for so many years – a holistic, health promotion approach.”

An avid and vocal supporter of allowing nurses to practise to full scope, Nitti attended the launch of Primary Solutions for Primary Care at Queen’s Park in June. She advocates for the empowerment of nurses because “they are a key piece in a sustainable healthcare system in Canada.” But she acknowledges not all physicians are on board.

“Traditionally, primary care was the family doctor in the family doctor’s office with the nurse sitting at the front desk,” she says. “Our health-care culture is really steeped in that. (Focusing on) team-based care (requires) a real shift in thinking.”

Nitti says she realized early into her career that nurses are allies on the healthcare team. “I can think of a number of cases where if a nurse hadn’t stepped in and said ‘what about this?’ or ‘what do you think of this?’ I would have made an error.”

When Nitti was practising as an emergency room physician at a Toronto hospital, she was called in to examine a patient who had blood in her urine. She diagnosed the patient with vaginal bleeding, arranged for a consultation with a gynecologist, and left her shift. An RN on duty would later discover the patient had a rectal bleed, and arranged to have the patient transferred to receive rapid care from an on-call ER physician. “We need to listen to nurses,” says Nitti, recalling the experience. “Especially in primary care, when, sometimes, they have closer and more frequent contact with the patients than we (doctors) do. They might pick up on something we’ve missed.”

The task force report speaks to the issue of physician compensation through a recommendation that challenges the Ministry of Health and the Ontario Medical Association to revamp physician payment models. This will ensure all health professionals are working to their full scope, while ensuring fair compensation for physicians.

Another recommendation urges the ministry to “develop a uniform and streamlined process to apply for additional funding to increase health human resources for primary care organizations when patient enrollment targets are met, and infrastructure capacity exists.” Thunder Bay’s Lakehead NPLC is one example, says Grinspun, who hand-delivered a request to Health Minister Deb Matthews last February. “Lakehead NPLC met its targets long ago. It has two exam rooms fully equipped and is still waiting for the government to approve its funding to add staff,” she says. “Meanwhile, patients without a primary care provider are waiting to enroll.”

Recruitment of nurses into primary care is a challenge recognized by many in the sector, including Judith Manson, executive director for the Sunnybrook FHT in Toronto. She represents the Association of Family Health Teams of Ontario on the task force. “If we want to recruit good people, we’ve got to make sure they’re being paid appropriately,” she says. “We’ve got to get the message out that these are good jobs.” This will lead to higher job satisfaction.
and retention, the task force argues. It will also mean stronger continuity of care for patients, and will help to expel the image of a primary care nurse “putting people in rooms, giving shots and not doing much else,” says Manson. “That old paradigm... is not true, but it’s still out there, even within the nursing group,” she says, adding: “We’ve got to educate our own.” This includes relaying real-life stories of nurses who have been working in primary care environments for years, says Manson. Some nurses have provided care to generations of families, which can be a very rewarding experience, she explains.

Building a strong rapport with patients is gratifying for RN Karen Lue-Kim, who works to her full scope at Lakehead’s NPLC. She says her patients appreciate her experience and knowledge, and the amount of time she spends with them. Many comment that they like discussing more than one health concern with her. In other health-care settings, patients are often booked to talk about one health issue. They are sometimes more willing to come back to the clinic, if necessary, because “they know there’s going to be that interaction,” Lue-Kim says. As a result, they want to take better care of their health.

NPs at the Lakehead clinic developed the RN and RPN roles in concert with Lue-Kim and RPN Michele Grace, who has taken on diabetes teaching because that’s her area of expertise. This frees up time for the NPs to focus on more complex cases, explains Pam Delgaty, clinical director. “We went over what jobs might be designated to them, keeping in mind their scope, their level of comfort and experience,” the NP explains. “We’re all nurses, and we all contribute together to meet the patient’s needs. We’re a team and collectively, we all have value.”

The Lakehead clinic opened in November 2010 and hit its capacity of 3,200 patients in less than one year. Lue-Kim helps to meet the demand, often offering same-day primary care for patients. In addition to taking pressure off NPs in the clinic, working to her full scope puts less stress on emergency departments and walk-in clinics in the community, she says.

Her schedule is always bustling. She’ll see anywhere from four to 11 patients daily. Typically, she’ll perform baby exams and physicals, administer immunizations, or look after patients with sore throats. She triages patients over the telephone, speaking with clients who have medication concerns or providing advice to those who are ill. The clinic is also developing a medical directive for an RN to prescribe medication for a urinary tract infection.

One of the second phase recommendations set out by the task force urges the College of Nurses of Ontario to implement regulatory changes that authorize RNs (in the general class) and RPNs to dispense medications. The document also advocates for RNs to be sanctioned to identify and communicate a diagnosis (within their level of competency), and suggests a shift away from medical directives, enabling RNs to consistent, in-depth care to patients.

“Terror tremendous satisfaction from my role here,” she says. “The job satisfaction, the personal fulfillment of being able to provide that care and build that rapport with the patient is amazing.”

The task force shares Lue-Kim’s wish, which is why its co-chairs Grinspun and Surridge have said they will continue to hold stakeholders’ and politicians’ feet to the fire to adopt all the recommendations by 2015. Doing so will lead to a brighter future for primary care in Ontario, Grinspun says. Phase 1 of Primary Solutions for Primary Care is currently in progress, and the report has already been adopted by the Joint Provincial Nursing Committee, which is comprised of leading government civil servants and nursing stakeholders.

“It’s RNAO’s duty to be a leader in shaping the health system,” says Grinspun. “Our role now, as nurses and as members of our community, is to mobilize everybody for speedy uptake of all the recommendations in this report, so the vision can become a reality, sooner rather than later.”

Melissa di Costanzo is staff writer at RNAO

In October, RNAO released Enhancing Community Care for Ontarians (ECCO), which builds on some of the recommendations contained in Primary Solutions for Primary Care. To read about ECCO, turn to Policy at Work (pg. 24).
It’s estimated there are more than 200 types of cancer. Prostate cancer remains the most commonly diagnosed cancer in Canadian men. Breast cancer continues to be the most can be prevented or detected early through screening and cancer will be diagnosed in Canada in 2012. More than 75,000 between the ages of 0 and 49 will account for approximately

Nurses have a unique role to play in the lives of patients diagnosed with cancer. In this issue of Registered Nurse Journal, we look at the experiences and views of four nurses from different vantage points. Whether facing a personal diagnosis, advocating environmental policies, or working directly with patients in pediatric oncology or palliative care, these RNs are doing amazing things to help those dealing with this pervasive chronic disease. By Melissa Di Costanzo
It’s estimated there are more than 200 types of cancer. Prostate cancer remains the most commonly diagnosed cancer among men. Breast cancer continues to be the most commonly diagnosed cancer among women. Half of cancers can be prevented or detected early through screening and health promotion. It’s estimated 186,400 new cases of Canadians are expected to die from the disease. Canadians 12 per cent of all new cancer diagnoses, and five per cent of cases are found in Canadians 50 to 79. Lung cancer is the lung cancer kills more people than breast, prostate and colon cancer in 2011. Cancer is one of four non-communicable diseases identified by the UN as causing premature death. The international organization has set a goal to reduce premature deaths caused by cancer by 25 per cent by 2025. April 3 marks Annual Oncology Nursing Day across Canada.
Diagnosis sends NP reeling

The spring of 2012 should have been a happy time for nurse practitioner Cheryl Dove. She was about to give birth to her second child, Julia, and was looking forward to maternity leave and spending more time at home with her two-year-old daughter Jenna.

Just days before Julia was born, 32-year-old Dove discovered a lump in her breast. Less than a month later, she was diagnosed with breast cancer. Nothing – not even almost a decade of nursing experience – could have prepared her for the news. Currently on leave from the North Muskoka Nurse Practitioner-Led Clinic, Dove admits: “I felt like my world was turned upside down. It was an overwhelmingly emotional experience.”

In the days following her diagnosis, Dove discussed treatment options with her husband, Mike, who is also an NP at the same clinic. They talked about how Dove was feeling, and what the next steps should be, just as though they were talking about a patient, she says. “I was in autopilot shock mode,” Dove admits, adding the news only began to really sink in when she was sitting in her oncologist’s office, staring at a medical bracelet with her name on it.

“Even now, sometimes, I feel like this can’t be me. But it is.”

After a battery of tests, eight rounds of chemotherapy (which wrapped up in October), and a double mastectomy, Dove says she takes every day one step at a time: “one foot in front of the other.” Losing her ability to breastfeed – something she could not do during chemotherapy – was especially difficult. “I still find it very upsetting,” she says. “I don’t know if I’ll ever completely get over it. It’s a grieving process.”

Dove has made many mental notes over the past seven months that she thinks will positively influence her practice – including telling patients to bring someone else along to appointments. They can be “very overwhelming” for a patient facing a cancer diagnosis and months of treatment. Dove’s husband accompanied her, and that made all the difference in the world: “As an NP, I thought ‘I’ll understand what the doctors are saying,’” she says. “But I wasn’t really taking it in. Bringing someone with you is very beneficial.”

Dove also plans to provide future patients with a primer about the health-care system, which has been described as maze-like by providers and clients alike. She had guidance from her husband and colleagues, but says an explanation of who does what is vital in order to calm the anxieties of patients who are already nervous and concerned about their health.

There is a lot of information available to patients following a diagnosis, Dove says. For instance, there’s financial assistance from cancer foundations, and volunteer services such as transportation. She can now confidently tell her patients this kind of help exists if they need it. It’s also helpful for health-care colleagues, who may be looking to provide extra support for their clients, to understand what’s available. Anything nurses can do to ease a cancer patient’s experience is precious, she says.

While it’s “different to be on the other side,” Dove says nurses have helped every step of the way. “It’s nice to know that health-care professionals really do have a positive impact on patient care. It really does make the situation more tolerable,” she says of having compassionate, understanding and helpful nurses and physicians.

One of the most powerful lessons Dove says she’s had since embarking on this difficult time in her life is the compassion of others. “[People’s] kindness has been so plentiful…from making meals for our family, to sending us well-wishes and words of encouragement, to the generosity of mothers providing breast milk for our baby…the support has been overwhelming,” she says. “It’s amazing how much strength you can draw from that.”

Children learn about cancer from classroom nurse

This spring, 14-year-old Joseph* learned he was living with osteogenic sarcoma, the same cancer Terry Fox was diagnosed with 35 years ago. Karen Drybrough, an RN at Toronto’s Hospital for Sick Children, was asked to speak to Joseph’s classmates. She is one of 10 Pediatric Oncology Group of Ontario (POGO) Interlink nurses who help young cancer patients feel more comfortable when resuming class after a diagnosis. Joseph wanted to hear the questions his fellow ninth graders were asking, and wanted to reassure them he was doing well. He stood next to Drybrough throughout the presentation, and though he seemed nervous, Drybrough says his courage impressed and inspired her.

Often, children are not present during her school visits because they’re undergoing treatment. “I was touched by how brave Joseph was, and how warmly his peers responded to him,” the Toronto RN recalls. “I don’t want to sugarcoat, because this is a difficult and stressful time for children and their families. But I see amazing personalities and spirits prevail.”

On average, Drybrough visits 80 schools each year in the Greater Toronto Area. She’ll answer students’ questions, and talk to them about cancer and its effects. When is my friend coming back to school? Why did he get sick? When are we going to get it? Does it hurt? These are just some of the difficult questions Drybrough faces on a regular basis.

She visits schools either at the beginning or the end of a child’s cancer treatment. She also visits if the prognosis changes, or if the child dies. Most teachers and principals have limited experience talking to students about the disease, she explains. “People hear the word ‘cancer,’ and it sets off a lot of alarm bells,” she says. “We need

* A pseudonym has been used to protect privacy.
to...help quell misinformation. Many pediatric cancers are curable now.” In fact, Drybrough says 75 per cent of children diagnosed with the disease survive.

School visits are only part of this pediatric oncology nurse’s role. She also links families to community supports, such as POGO. And she is involved in palliative care co-ordination and advocates for the development of community supports, such as parent support groups. Drybrough’s able to see how patients and their families live outside hospital walls, allowing her to better understand how the disease impacts health, wellbeing, relationships and jobs.

She recognizes the toll that working with this population can take, and accesses creative outlets to find balance in her life. In her spare time, Drybrough volunteers with a Toronto theatre company. She draws on her experience as an actor and producer to help her better relate to the children she meets during her classroom visits.

“It’s joyful, rejuvenating, and there is no doubt in my mind it has helped sustain me in pediatric oncology,” she says.

Drybrough also admits that bringing her theatre experience into the classroom helps her stay animated when speaking to children. “When you’re presenting, you can, perhaps, fall back to a less natural, more scripted way of speaking,” she explains. “My theatre experience has taught me to keep it natural and to be myself. (This helps) when connecting with the kids.”

After 35 years of working with children, Drybrough says it “gets into your blood and into your bones.” She has encountered profoundly difficult experiences throughout her career. The passing of a youngster is never easy, she says. But the resiliency of the human spirit has kept her in the role. “When you see a child finish treatment and get back to school and get back to their home life, it’s very gratifying.”

Prevention strategy must include environmental policy

Morgan Lincoln knows the devastating effects cancer can have on a family. Her aunt passed away from leukemia at the age of five. Her grandfather died of a brain tumour when she was 10. And in 2009, Lincoln’s mother learned she had breast cancer.

After her mother’s diagnosis, Lincoln began her nursing degree at the University of Toronto. She had an interest in environmental health and noticed cancer prevention programs focused on maintaining a healthy, smoke-free lifestyle. Early screening was also offered as a pre-emptive tool.

While these messages are important, they “generally eclipse environmental factors, such as air pollution, or toxins in consumer products,” says the Toronto native and president-elect of RNAO’s Ontario Nurses for the Environment Interest Group (ONEIG). According to the Canadian Cancer Society, harmful – or potentially harmful – substances include: non-stick cookware, arsenic in drinking water, pesticides and radon. Environmental risks include: radiofrequency fields and medical radiation.

Lincoln believes stringent regulations around carcinogens need to be created and enforced at the federal, provincial and municipal levels. Nurses, with their holistic view of health, are in a strong position to advocate for cancer prevention politically, she says. In fact, ongoing political activity by RNs will keep these environmental risks top-of-mind for policy makers, she adds.
The majority of work ONEIG is currently focused on aims to do just that. Three ONEIG resolutions – all linked to cancer prevention – were passed at RNAO’s 2012 annual general meeting. The group has urged RNAO to support policy that will: reduce vehicle idling, including drive-through emissions; ban the mining, processing, use and export of all forms of asbestos; and reduce the risk of exposure to carbon monoxide and nitrogen dioxide due to emissions from ice re-surfacer in arenas.

ONEIG is pushing for these changes so Canadians can breathe easier, but its work is not limited to these resolutions. In the fall, the group organized a Greening Health Care event, where sustainability initiatives in place at Toronto’s University Health Network were discussed. RNAO and the Canadian Nurses Association have also passed ONEIG resolutions related to the amount of lead children are exposed to.

Lincoln says few people realize how closely their health and the environment are linked, which is what drives her involvement with ONEIG. “They’re inextricable,” she says, suggesting peoples’ lack of understanding may relate to the lapse in time between exposure and the onset of disease. Breathing air polluted by diesel exhaust, which has been labeled a carcinogen by the International Agency for Research on Cancer, is exposure, but some people may not be diagnosed with cancer until years later, she explains. “We can touch a stove and see a blister or burn right away. This is like constantly touching a hot stove, or being in a toxic soup, but not seeing the effects until way down the line.”

Lincoln’s motivation stems from her family’s history with cancer, but her clinical experience has also shaped her focus. In the fall of 2011, she was completing a placement in oncology at Toronto’s Princess Margaret Hospital. One day, she learned two people on the unit had been diagnosed with mesothelioma – a rare cancer primarily caused by asbestos exposure. She was surprised to hear that two patients were living with the same uncommon cancer. The experience reinforced her passion for holding political leaders accountable. When it comes to cancer prevention, this is “a warning for what’s potentially to come if we don’t get serious (about protecting our environment).”

Precious time at end-of-life is premise of new book

Grace Bradish has provided care for hundreds of patients over her 35-year nursing career. Few have had the impact on her that Rob Fazakerley and his wife, Jen, have. “I tell my patients on a daily basis: my job is to help you find joy in living today, because I can’t tell you what’s coming tomorrow,” she says. “Jen and Rob really lived that (philosophy).”

Bradish was the home-visiting nurse practitioner at London’s South West Community Care Access Centre assigned to Rob’s care when he was diagnosed with terminal pancreatic cancer in August 2009. He was only 46. She’s also the co-author of a new book called Just Stay, a novel about Rob and Jen’s last months together.

After his diagnosis, Bradish met numerous times with Rob, Fazakerley and his wife, Jen. “I warn families about this: that regardless of how much they’re anticipating…that final breath, that absence of pulse carries an element of shock and surprise that one can comprehend. “I warn families about this: that regardless of how much they’re anticipating…that final breath, that absence of pulse carries an element of shock and surprise that one can never anticipate,” she says. “(When Rob died) I felt that.”

A few months later, Bradish gathered together 300+ emails she had exchanged with the couple and Butlin-Battler. She sent them to Jen, and talked to her about the wealth of her experience. It could be beneficial to other patients, families and health providers, she said. Discussions ensued, and the idea for Just Stay was born.

For two years after Rob’s death, Bradish, Butlin-Battler and Jen collaborated on the book. Sometimes, they found themselves writing in pairs due to conflicting schedules. All three were first-time authors, and the writing experience, Bradish says, was very powerful. “There were sections of the book where, if we didn’t cry together when we were writing, I know we certainly had tears when we parted and went our own ways.”

The book, which, in part, is a reflection of Bradish’s approach as a palliative care nurse, was released in September. Since then, people have been telling her they can’t put it down. She hopes Just Stay gives readers “confidence that, despite a loved one’s departure…there will remain a significant presence with those whom they loved.” For health-care providers, her wish is that the book “releases them from the awkwardness that we all experience in having these very difficult conversations with people. We are so afraid to use the “d” word, and yet, death is what makes life so terribly precious.”

RN Grace Bradish (left) co-authored Just Stay, a book about one man’s end-of-life experience, with Jen Fazakerley (centre) and Helen Butlin-Battler.
RN becomes leader to inspire others
HAMILTON NURSE ALWAYS KNEW A LEADERSHIP POSITION WOULD ALLOW HER TO HELP COLLEAGUES SEE THEIR INFLUENCE.

Anne’s* words are seared into Denise Bryant-Lukosius’ memory: “I can’t watch her suffer anymore.” The distraught woman was referring to her 19-year-old daughter, Laura, at a patient at St. Joseph’s Healthcare in Hamilton when Bryant-Lukosius worked there almost 30 years ago. The young girl had been diagnosed with a rare type of non-Hodgkin lymphoma and was not responding to chemotherapy. Anne was distressed, and unsure of her daughter’s prognosis.

A hematology oncology nurse at the time, Bryant-Lukosius had three years of nursing under her belt. She was beginning to understand how RNs can help to turn difficult situations into positive – even life-transforming – moments.

Leading Anne out of the hospital and into the bright sunshine, Bryant-Lukosius sat down on the curb with the worried mother and held her hand. “I think we’re going to make it through this. Have faith,” she told her. She provided the same kind of one-on-one support to Laura, whose health began to improve after the first two difficult weeks of treatment. Laura is now in her early 50s and cancer-free. Over the years, she has shared her story at conferences, and Bryant-Lukosius is grateful that others have heard directly from a patient just how important strong nursing care can be.

As a teenager, Bryant-Lukosius spent time as a patient in hospital. She noticed nurses can “forget they’re the one single person who can change the whole experience – and perhaps even the health outcomes – of patients.” She always knew she wanted to be a nurse, and says her early exposure to nurses’ lack of confidence reinforced her desire to become a leader in the field who could help colleagues comprehend their pivotal role.

Anne was one of the first patients Bryant-Lukosius met in her career, and one day stopped her in the hallway, asking: “So Denise, when are you going to get your master’s?” It was a moment Bryant-Lukosius says changed her career. “I might not be where I am today,” she says, acknowledging the prod from Green really helped to boost her confidence in her capabilities, and resulted in a master’s degree from D’Youville College in 1993. “Everyone needs someone in their corner.”

After nine years at St. Joseph’s, Bryant-Lukosius moved to Hamilton Health Sciences (HHS) as a clinical nurse specialist in hematology/oncology. Her involvement with McMaster – where she would later obtain her PhD – began shortly after arriving at HHS, and continues today.

In addition to teaching at the University, Bryant-Lukosius has a cross-appointment as a nurse clinician scientist at Hamilton’s Juravinski Cancer Centre, where she’s director of the Canadian Centre of Excellence in Oncology Advanced Practice Nursing (OAPN). A signature initiative of OAPN – and a program that is very close to this nurse leader’s heart – is the Ontario Oncology Nursing e-Mentoring Program. Bryant-Lukosius leads this program that, since its inception in 2007, has seen over 200 mentors and mentees in oncology working together to boost their knowledge and skills. “We can’t expect nurses to consistently deliver (high-quality care) if we don’t provide them with the support to do (so),” she explains. “It’s a tough, demanding job.”

Bryant-Lukosius is passionate about helping nurses to develop greater confidence. When she hears nurses talking about how the program changed their practice, “...it’s very inspiring,” she says. “You just see the...potential for nursing to make such an important difference in the lives of patients and families.”

* Pseudonyms have been used to protect privacy.

Three things you don’t know about Denise Bryant-Lukosius:

1. She enjoys scotch – in particular, 21-year-old single malt scotch.
2. Her cousin, Tyler Bozak, plays for the Toronto Maple Leafs.
3. Her favourite place is “as far north as possible,” sitting in a boat in the middle of a lake catching fish.

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More than quick fix needed to deal with elder abuse

RNAO’s work on the prevention of elder abuse took centre stage at a House of Commons committee meeting in Ottawa on Oct. 16. Josie Santos, the RN who is leading the association’s work on this issue, was invited to appear before MPs to provide feedback on a change to the criminal code. The amendment would consider “vulnerability due to age” as a factor for judges to consider when sentencing individuals found guilty of committing abuse against seniors.

While Santos spoke in favour of Bill C-36, Protecting Canada’s Seniors, she said the legislation would not produce the changes needed to end elder abuse, nor would it have any impact on the many instances that go unreported. RNAO wants to see greater emphasis on the root causes of elder abuse, such as poverty, she told the committee. It also wants to see more programs on prevention and intervention, as well as better support services for seniors and their families and caregivers.

Two years ago, RNAO led a national project to raise awareness of the issue in long-term care homes. It also created a curriculum to help health-care workers learn how to identify instances of elder abuse and neglect, and how to intervene.

To read the ECCO report, commentaries and to view webinars, visit www.RNAO.ca/ECCO

New model for community care receives much attention

A landmark report that calls for a major re-think about the way home care and support services are delivered in Ontario was released by RNAO in October. Titled Enhancing Community Care for Ontarians (ECCO), the report offers the Ministry of Health a model to create a more robust primary care system. It is a three-year plan with clear targets and timelines.

Currently, home and support services are handled through 14 Community Care Access Centres (CCAC). However, RNAO believes costly duplication that exists between CCACs and other sectors is hampering the province’s ability to achieve greater system integration and efficiency.

According to the auditor general, in 2008/09, $163 million of the CCACs’ $2 billion budget was earmarked for administrative expenses alone. RNAO argues that money could translate into four million additional hours of direct home health care if CCACs were phased out.

The report proposes that the 3,500 case managers and care co-ordinators (3,000 of whom are RNs) who currently work for CCACs could be better utilized providing their care co-ordination and system navigation expertise in primary care settings such as nurse practitioner-led clinics, community health centres, family health teams and aboriginal health access centres.

ECCO recommends a Primary Care Transitional Secretariat, placed within each of the province’s 14 Local Health Integration Networks (LHIN), to help with the formation of local primary care hubs that support primary care providers until the model is fully operational.

RNAO believes transitioning CCAC case managers and care co-ordinators to primary care – while maintaining their same compensation – will provide people in Ontario with same-day access to primary care, including enhanced health promotion and disease prevention programs, as well as chronic disease management and in-depth care co-ordination for the most complex patients. RNAO CEO Doris Grinspun says another benefit of this model is that LHINs would assume planning, funding allocation, and accountability for the whole system, not just part of the system as they do now.

Sale of Shouldice Hospital stopped

A record number of members responded to RNAO’s action alert about the proposed sale of Shouldice Hospital to Centric Health, a company controlled by a large American conglomerate. About 2,500 members and friends of RNAO sent letters to the Ministry of Health urging it to reject the deal.

Hospitals in Ontario are governed under the Public Hospitals Act and are not-for-profit entities. An exception was made for the Thornhill-based Shouldice, renowned for its treatment of hernias, because it existed long before Medicare.

RNAO argued that even though the family that founded and still operates the hospital wants to sell, it should remain a public entity and not be sold to a for-profit company.

In a letter to the minister of health, RNAO President Rhonda Seidman-Carlson and CEO Doris Grinspun called on the provincial government to reject the deal and re-commit to the Canada Health Act and the fundamental principle of a single tier health-care system where patients, not profits, are emphasized.

In early November, Centric Health announced it was abandoning its bid to buy Shouldice. RN
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When I think about nursing, I think about possibility and leadership. But I didn’t always think this way. As a student five years ago, I learned that this profession is versatile and rewarding, but I seldom associated nursing with leadership. I thought it was a title or position I may aspire to later in my career. But when I look back on my past year of practice, I see someone who has become a leader without the formal title.

Last year, I had an 84-year-old patient who was admitted to the general internal medicine unit from home. She had mid-stage dementia and was non-verbal. Mrs. B* had not eaten properly over the past two weeks. The interdisciplinary team discussed the possibility of inserting a gastric tube to provide her with some much-needed nutrition and to keep her hydrated. Her family’s concern was palpable. They informed us that she usually had a good appetite and it was a shock to see her this way.

While a colleague and I provided care for Mrs. B several days into her stay, my colleague said: “Maybe we should clean her dentures.” Eureka! What a breakthrough this was. We discovered Mrs. B was pocketing food. The sores in her mouth were plentiful and raw, indicating the dentures had not been removed for quite some time. It was no wonder she was not interested in eating. A rigorous oral care plan and treatment interventions followed, and within a week, Mrs. B’s oral intake had increased and she had regained her strength. She was discharged home without a feeding tube.

This experience struck a nerve, and reminded me that basic oral hygiene has a significant impact on a patient’s overall health status. I decided this was a clinical issue that needed more attention in acute care. Mrs. B was the catalyst for several leadership opportunities that have since enriched my practice and reshaped the way I see nursing.

Last year, I led a quality improvement project at my organization through two nursing fellowship programs: the University Health Network’s Nurses for Tomorrow Innovation and Research Fellowship and RNAO’s Advanced Clinical Practice Fellowship. These experiences were not only uplifting; they also rejuvenated my passion for what I do.

When I think about nursing, I think about individuals who see possibility in their work. Nurses demonstrate leadership from where they stand, no matter the role. We talked about this a lot in our fellowship group discussions and now I see how strongly this notion of leadership resonates in all of my work. RN

Michelle How Pak Hing is a staff nurse in general internal medicine at Toronto Western Hospital. She is also a research assistant at the School of Nursing at York University.

* A pseudonym has been used to protect privacy.
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