SEPTEMBER/OCTOBER 2016

REGISTERED NURSE JOURNAL

Out of Harm's Way

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

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REGISTERED NURSE
JOURNAL

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RNAO
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EDITOR'S NOTE KIMBERLEY KEARSEY

Every story, perspective and opinion is valuable

IN OUR SUMMER ISSUE OF THE *Journal*, we brought you some of the findings of our survey of readers (*July/August, Your Say*, page 7). I want to take this opportunity to clarify some of the numbers. We began the survey in December 2015. At the time we were compiling our analysis, 122 members had weighed in on our five questions, and in most cases anonymously. Much of the information gathered was anecdotal in nature. It is important to note that these respondents do not represent the majority of RNAO members. The information shared in the summer issue was from a very small group relative to our total membership. We value every one of those 122 readers' opinions, but want to clarify that we were not drawing our numbers from a pool of thousands as was implied in our last issue.

The ideas and perspectives that our survey respondents shared will help to bring future issues of the *Journal* to life. We rely on these ideas and perspectives for every issue, and September/October is no exception. In fact, our feature about nurses' participation in inquests (page 24) came directly from Laura Jackson, who contacted home office to offer up her insights as a juror at a coroner's inquest. Had she not come forward to volunteer details of her experience, we would not have been able to tell this story. Our feature about NP prescribing of controlled substances (page 20) touches on an issue that has been on RNAO's list of policy priorities for a long time, but the nurses who bring it to life – David Free and Jason Sawyer – also approached RNAO for a meeting with our policy department and CEO on the issue. They wanted a chance to express their concerns and share their experiences, which have translated into another story for the magazine.

In September, I had the opportunity to speak to RNAO's assembly members who were meeting in Toronto. I talked about the magazine, and specifically about submissions and stories. My message from the podium is the same as my message in print: we need your stories. If you think to yourself 'I'm not a writer' or 'nobody wants to hear my story,' please take it from me; that is simply not true.

Every story is valuable, and we want to hear it. It might be over the phone (416-599-1925), in an email (editor@RNAO.ca), or anonymously through our survey (www.myrnao.ca/RNJSurvey2015-2016). As long as it comes from the heart, and it's important to you, it will be important to others. **RN**

Joining RNAO: Joining a winning team

Recently, I had the privilege of attending an appreciation event that Region 7 (Toronto East) organized. Several nursing students were recognized for going the extra mile to spread the word about the benefits of RNAO, and for embodying all of the things that make our association as influential as it is. During this celebration, other significant achievements were marked, including the region's *Chapter of the Year* recognition award (received at RNAO's AGM last May), and the addition of 400 new nursing students to the chapter.

I was so very proud and couldn't help but marvel at the exposure and experience nursing students are getting by being members of RNAO before they graduate. Some have positions on the local executive, while others are gaining valuable experience organizing events. I could feel the energy in the room and asked myself: "What will these students be doing five or 10 years from now? How will they be contributing to RNAO to help it continue to grow?"

Thinking back about that evening, I realize I didn't have the good fortune to be a member of RNAO during my studies or early in my career. In fact, it wasn't until much later, when chatting with colleagues in public health, that I learned what I was missing. They would tell me about different interest groups they belonged to, or about committees they were part of. As I began hearing about all of the interesting activities they were involved in across a range of professional and health issues, I have to confess I asked them how they got involved. They told me: "Through RNAO."

My colleagues seemed to be connected and I realized I was missing out. I was missing the richness of the nursing perspective and voice. For example, I wasn't hearing what nurses had to say about an issue such as homelessness.

I may have come to this realization later in my career, but I have never looked back since joining 15 years ago. I have been part of several interest groups. I have met nurses in these groups who have deepened my connection to my areas of interest, helped to stretch my understanding of issues, and broadened my perspective across different practice settings.

In addition to being part of several interest groups, I have had the privilege of being on the board of directors, first as the member-at-large for nursing administration before becoming president-elect, and now as president.

RNAO membership is voluntary, which means you have to renew each year – unless you choose continuous membership, which I strongly advise you do. This voluntary aspect is vital to the association. You belong to RNAO because you believe in its mandate to speak out for nursing and for health, because you believe in the power of RNAO, and how our collective influence is strengthening our profession, the health system in which we work, and the health of Ontarians. That belief and trust in what the association does for you has to be earned each year. We know and respect that.

> "As we approach another membership year, remember we need you to reach our goals. Each one of you is an ambassador for RNAO."

As we approach another membership year, remember we need you to reach our goals. Each one of you is an ambassador for RNAO. If you haven't already renewed your membership, please do so right away. And please encourage colleagues to join by sharing with them the value that RNAO membership brings to their practice and their career. It opens career doors. It exposes you to different dimensions of our profession. And, with its international best practice guidelines program, RNAO continues to elevate patient and client care to a whole new level.

Being a member of RNAO – your professional association – is an incredible way to stay informed about what is happening in nursing and what is happening throughout our health system. You learn how policy is created and how the provincial legislature works. You engage in advocacy that influences and shapes health policy. Membership exposes you to important discussions that affect your practice, such as end-of-life decisions, how income is a key determinant of health, and how low-cost offloading devices for those with diabetes can make the difference between a person keeping or losing a limb.

With 41,000 RNs, NPs and nursing students, we are shaping the future of nursing, health care and health. This is why we need you, and many more, to continue to take nursing and health to even greater heights. **RN**

Carol Timmings, RN, BScN, MEd (Admin), is president of RNAO.

SIS: Keep the conversation going

As ontario looks ahead to greater access to supervised injection services (SIS), I want to talk about one of the most important things we must remember as we wade through these new waters. People who struggle with addiction and substance use are people, like you and me. Addiction is not a choice. And their individual stories of struggle are as unique as the individuals themselves.

RNAO and its members must remember this as we work with our partners in health care to establish SIS across Ontario. Let's also keep three vital things in mind as we move ahead: never cut ties with individuals who struggle with addiction; never judge; and never shut people out or reject them on the basis of unfound bias. Instead, let's open our hearts, initiate dialogue, and offer support.

Most of us would agree that accessing care for addiction or substance use should not be more difficult than accessing care for cancer, diabetes, COPD or any other health issue. Patients and clients with physical illnesses receive expert and compassionate care from nurses in all sectors and settings. The same ought to be true for anyone who needs help.

RNAO has enlisted experts in the field of mental health and addiction (since these challenges often go hand-in-hand) to help us build on this notion of equal access. We look to RNs like Lynn Anne Mulrooney, an RNAO senior policy analyst, and Sabrina Merali, one of our talented program managers in the IABPG Centre, who have led initiatives at RNAO that have helped to lift the lid on myths associated with mental health and substance use.

I am particularly proud of our Mental Health and Addiction Initiative, and its one-of-a-kind Youth Mental Health and Addiction Champions project that connects youth with school counsellors and public health RNs and NPs. Together they build a network of champions who help with mental health promotion, stigma reduction, and substance misuse prevention in high schools. This project has inspired me in its capacity to create an intersectoral sense of community to tackle the difficult challenges our youth face.

RNAO has also advanced and enhanced knowledge on mental health and addictions through its best practice guidelines (BPG). Our *Engaging Clients Who Use Substances* BPG offers evidence-based recommendations for assessing and providing interventions to individuals who may be at risk for or experiencing a substance use disorder. *Supporting Clients on Methadone Maintenance Treatment* (MMT) is another BPG that provides nurses with the best evidence for supporting clients who are either a potential candidate for, or are already on, MMT for opioid dependence.

It was extremely fulfilling this spring to receive a formal letter from David McKeown, Toronto's former medical officer of health, asking RNAO to develop a BPG on SIS following the city's approval of the services at three sites. He, like RNAO, is a steadfast champion for SIS. In fact, he brought the proposal for these important services to Toronto's board of health. I am thrilled that he has accepted our invitation to serve as a panel co-chair for this important BPG.

> "IN A SMALL WAY, THIS ONGOING DIALOGUE WILL KEEP THE MANY LIVES LOST TO ADDICTION IN OUR HEARTS AND MINDS."

The panel of experts for the guideline will also include Cori Chapman, the mother of Leigh (featured on page 12) and Brad Chapman, whose preventable death last year from overdose helped to shine a light on the pressing need for services in this city. People like Cori, who have lived experience and have lost loved ones to addiction, will be central to the development of the SIS BPG. Their important experiences will inform our recommendations and help us to remember that addiction is an illness that can affect any one of us at any time.

Some opponents of harm reduction practices, such as SIS, say they don't want these services in their own backyards. Perhaps they want to ignore the fact that addiction and substance use is already in our own backyards. RNAO's own Nancy Campbell, director of finance, took a photo this spring of a syringe at St. James Park and asked her followers on Twitter if they would rather see syringes in the park or at supervised injection sites. RNAO member Amanda Dodge tweeted "We are fully behind you" when she heard I was preparing for a presentation to Toronto's Board of Health on behalf of RNAO. These individual tweets, and this open dialogue about addiction and substance use is making a difference.

I urge all nurses – RNs, NPs and RPNs – nursing students, and the public at large to keep the conversation going. In a small way, this ongoing dialogue will keep the many lives lost to addiction in our hearts and minds. It will help us push the harm reduction agenda faster, and will provide comfort to families that those lives were not lost in vain. **RN**

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

Follow me on Twitter @ DorisGrinspun

 BY VICTORIA ALARCON

From 'barely getting by' to blossoming

RESILIENT, HARD-WORKING RN SEES HER DIFFICULT YOUTH AS A BLESSING IN DISGUISE.

Growing up, Kerri Ann Podwinski never had it easy. She left home at the age of 14 and struggled with depression and anxiety as well as her family's reluctance to accept her sexual orientation. She slept at friends' houses, in bank vestibules, and just about any place that was open after dark. She relied on friends for clothing and food, but there were times she would go three to four days without eating.

Being homeless can affect a person in many different ways. It's a daily struggle to cope with ongoing hardships, including addiction. However, for Podwinski, the struggles were more centred around school, where she earned 50s in some classes and stopped attending others completely. She was on the verge of dropping out when she met with a school counsellor who suggested the Second Chance Program, an initiative that allows students to work at their own pace and complete credits in a more open environment, away from school.

With limited options, she enrolled in the program. She didn't think much of it until she met her teacher, Jon Bald.

"He was the only one who ever told me I could do anything," says Podwinski of his encouragement and bluntness. He made her rethink her life.

It was also thanks to Bald that Podwinski first thought about going into nursing. He mentioned the profession would be a perfect fit given her interest in science and her caring demeanor.

Podwinski took his advice to heart and volunteered at an emergency centre at St. Catharines General Hospital as well as a rehabilitation centre called Power Cord. As a volunteer at the hospital, she saw the work of nurses firsthand. At the rehabilitation centre, she began to discover the connection she was able to build with the patients she assisted.

PHOTO: BROCK UNIVERSITY

Three things you didn't know about Kerri Ann Podwinski:

1. She likes to paint in her spare time.
2. She has tattoos covering most of her body.
3. She is a fan of alternative metal music and Marilyn Manson.

"The therapeutic relationships that I built with these people, and the improvement I saw (in them)... it was just really nice," she says, adding that she realized nursing would provide her with more opportunities to work closely with people. She knew she was capable of becoming a nurse if she studied hard.

With this goal in mind, Podwinski pushed herself to finish high school in 2010 and finally found a place to call home in student housing at Brock University, where she began working in the cafe. She knew she had to improve her high school grades and gain the necessary prerequisites to be accepted into the university's nursing program. Attending night classes and online learning courses for two years, Podwinski studied hard while juggling three jobs.

She was able to boost her grades from 50s to 90s, and finally applied to the university's nursing program. "I just wanted to make something of myself. Prove to myself that I could do something that people told me I was never (going to be) capable of."

She waited, nervous and unsure if she would get in. When she received her acceptance letter in 2012, she was speechless. "I just broke down crying. I couldn't believe I was accepted into university," she says.

Podwinski's hard work and determination did not stop there. In her first year at Brock, she became a member of a university program where she participated in weekly health-care-centred skills development workshops and speaker sessions to hone her skills. In her third year, she co-founded the Brock University Nursing Student Alliance, creating a community for nursing students to network.

Podwinski graduated in 2015 and was able to secure a six-month nursing position at North York General Hospital through the government's Nursing Graduate Guarantee Initiative. She is now a registered nurse on the telemetry unit at St. Catharines General Hospital, and also works at Hotel Dieu Shaver Health and Rehabilitation Centre in the same city.

The 23-year-old RN says she wants to continue her education, and intends to pursue her master's degree next fall and her PhD down the road.

Looking back, she reflects that her experience with homelessness taught her to appreciate things a lot more in her life: a bed to sleep in and a home to go to. She's been able to re-establish a relationship with her family, but is still grateful that the difficulties she faced in her early teens made her the resilient, hard worker she is today. Asked if she has any regrets, Podwinski says she wouldn't change a thing in her life.

"If anything was different, I wouldn't be the person I am today." **RN**

Victoria Alarcon is editorial assistant for RNAO.

NURSING IN TH

NP Lynn Grandmaison Dumond wants more people to understand just what goes on in a hospice for children.

Opening up about palliative care for kids

For some families, and even some physicians, it is hard to accept the benefits of palliative care for a child. Some find it too difficult to even talk about, says **Lynn Grandmaison Dumond**, a nurse practitioner at Ottawa's Roger Neilson House, an eight-bed hospice for children and youth 19 and under. Although pediatric palliative care has expanded across the country since 2006, it is a specialty that still faces some hurdles, including the view that palliative care is like giving up hope. "We hear a variety of things. Some think coming to Roger's House will be doom and gloom. It is nothing like that. Children are well-entertained and enjoy their days here. It is a happy and bright place to be," the Ottawa NP says, adding: "Many people have no idea what we do here." Research suggests that patients who receive palliative care earlier often do better and live longer. To overcome fears around the dying process, Grandmaison Dumond says we all have to look at end of life as "... living, and how you can make those weeks, months, years the best they can be." Talking about death to loved ones is important, she adds. "It is a privilege to be able to discuss living and dying." (*Ottawa Sun,* Oct. 3)

Public vs. private care

A highly public court case underway in Vancouver is threatening the country's publicly funded, not-for-profit health system, says RNAO President **Carol Timmings**. Brian Day, a B.C. physician who operates a private surgical clinic, is challenging the ban on private health care in that province, saying people should be able to buy access to health care. RNAO believes private health care will only benefit a small group of people who have money to pay out-of-pocket to get health care. "The path to improving our health system is not through compromising its core values, but instead through increasing universal access by using all health professionals to their full scope of practice, anchoring the system in primary care, creating stronger community care services, and ensuring the use of evidence-based practice," says Timmings. Under current laws, every Canadian is entitled to medically necessary services specified under the *Canada Health Act,* without charge. (*Radio Canada International,* Sept. 2)

Hospital lowers wait times

People seeking help with drug and alcohol addiction no longer have to wait several weeks to receive treatment at Bluewater Health. Since the launch of the organization's withdrawal management services program in 2014, the wait time is now

Paula Reaume-Zimmer

less than a day. "When someone is ready to make a major life change, such as leaving an addictive behaviour, it's critical we can offer the service as soon as possible," says **Paula Reaume-Zimmer**, vice-president of Bluewater's mental health and addiction services. The program has helped more than 700 people since 2014 and counsellors have been able to meet with clients in their homes, in public places, and in other community clinics. The next step for the hospital, Reaume-Zimmer says, will be building a 24-bed, community based detox hub facility in Sarnia, which she hopes will open in late 2017. The hub will incorporate the existing withdrawal management services, detox beds, and will work closely with residential rehabilitation facilities. Reaume-Zimmer says, once the hub is up and running, wait times will be something to watch as demand is expected to increase. (*Sarnia Observer,* Sept. 2)

Security must be a priority

In an interview with *CBC's Ontario Today* (Aug. 11), RNAO CEO **Doris Grinspun** says health-care organizations must

E NEWS

BY VICTORIA ALARCON

have a zero tolerance policy for aggression and violence. “Organizations have an obligation to protect their employees,” says Grinspun, adding that prevention of violence in the workplace requires mandatory education, additional supports for nurses, and taking action as soon as a violent incident is reported. Grinspun’s remarks were timely given that a week after her radio appearance, there was news of a security system failure at Hamilton’s St. Joseph’s Healthcare West 5th campus. On Aug. 19, a staff member’s personal alarm system malfunctioned when the individual tried to alert colleagues that a patient assaulted another patient and threatened staff on a second-floor nursing unit. During the incident, the security system incorrectly located the staffer on the first floor instead of locating the individual on the second floor. The hospital has given its security contractor six months to fix the system so a similar incident does not happen again. **Winnie Doyle**, vice-president of clinical programs and chief nursing executive, says they expect to have a system “...that is highly reliable all the time.” (*Hamilton Spectator*, Aug. 29)

TOP PHOTO: BRENDA STOCKTON-GRUNDT/MYWAWA.CA

Educating others about hepatitis C

A group of nurses in Northern Ontario are raising awareness about hepatitis C in marginalized populations. **Camille Lavoie**, **Paola Folino**, **Keri McGuire-Trahan**, **Kelsey Secord** and Catherine Woldanski embarked on a five-day hepatitis C northern road show in September. Along with help from colleagues at AIDS Committee of North Bay & Area, Réseau Access Network Sudbury, and the Sault Ste. Marie Group Health Centre, the nurses provided important testing opportunities for residents in outlying locations such as Espanola, Pic Mobert and Cochrane. They also provided educational opportunities to the public. “Mobilizing access to services for hepatitis gave us an opportunity to inform people about our ministry of health funded programs such as treatment for hepatitis C, harm reduction supplies and needle exchange,” McGuire-Trahan says. Hepatitis C, which is spread through contact with infected blood, is a major burden on the health-care system, infecting between 3,200 and 5,000 people in Canada annually, according to the Canadian Centre for Occupational Health and Safety. The team will be looking into making smaller road trips to help more hard-to-reach populations. (*North Bay Nugget*, Sept. 8)

Health providers in northern Ontario are reaching out to remote communities with education about hepatitis C. Among them (L to R) are Desireé Beck, Ashley Archambault, Kelsey Secord, Paola Folino, Keri McGuire-Trahan, Camille Lavoie, and Catherine Woldanski.

RNAO’s Irmajean Bajnok (centre) speaks to Fairchild TV in August.

Promoting prevention

Each year, almost 2,000 Ontarians are forced to endure a diabetes-related amputation. Many could be spared the procedure with better prevention. People with diabetes are at high risk for foot ulcers. If those ulcers become too severe, they could lose a limb. RNAO International Affairs and Best Practice Guidelines (IABPG) Director **Irmajean Bajnok** says that with the right measures in place to prevent foot ulcers, and if appropriate treatment is given to those who have foot ulcers, Ontario could help save limbs and money since an amputation costs about $70,000. “The amputation just increases in cost because you need many kinds of rehab services; you may not go to work for a while and the quality of life is sad for many people who lose a limb,” says Bajnok. According to the Canadian Association of Wound Care and RNAO’s best practice guideline *Assessment and Management of Foot Ulcers for People with Diabetes*, second edition, preventive measures, such as controlling blood glucose levels, quitting smoking, and exercising daily will keep feet healthy for those with the chronic illness. In addition, providing offloading devices to all Ontarians living with diabetes, as well as ensuring they have at least one foot assessment annually by a qualified health professional, will make a difference. (*Fairchild TV*, Aug. 31) **RN**

NURSING IN THE NEWS

Letter to the editor

Concerned about the safety of pedestrians, RN **Shehnaaz Mohamed** *pens a letter to* yorkregion.com *about dangerous driving in Thornhill.* (Aug. 18)

Dangerous driving compromises pedestrian safety

I have been a proud Thornhill resident since 2002, who has always prided myself in being involved in my kids' schools and local events.

This year, I have almost been hit by a car about five times while crossing a Thornhill street — in each case in broad daylight. It has been at the major intersection of Don Mills and Simonston Blvd., where it has been the pedestrian's right of way.

Now, I am very hesitant and I make eye contact before crossing.

During school time, I try to use the crossing guards and I tell them if ever their positions get eliminated, I will be the first to fight for them.

Yesterday was the last straw. I was crossing at a four-way stop sign at Simonston Blvd and Waggoner's Wells at 6:10 p.m. It was broad daylight. I stopped and a couple of cars just went through, then finally the car that had the right-of-way stopped, I waved, and started crossing. Suddenly the car making the left turn (which did not have right-of-way and had come to a stop before I started crossing) started approaching me. I screamed STOP. It had tinted windows. A white sedan. It picked up speed. I had to make a jump and a dash to save my life.

It carried on and I didn't get the licence plate. The driver of the car that had right-of-way threw her hands up in disbelief too.

In 2014, I survived breast cancer and have just gone back to work full-time. I work as a nurse, and am used to work in ICU and ER, so I have seen my share of people getting disabled by accidents.

I am getting scared to cross the road without another person there. I said to my husband: If cancer didn't kill me, these drivers are going to kill or maim me.

I have also seen two other people escape being hit by a vehicle at Don Mills and Simonston Blvd.

I am not sure what can be done to decrease the near misses and make drivers more responsible. I am sure other Thornhill residents are feeling the same, and when winter approaches, the days will be getting shorter and the risk higher.

I really feel pedestrian safety is highly compromised and something should be done.

OUT AND ABOUT

RNAO PARTNERS WITH HEALTH QUALITY ONTARIO

Members of RNAO's board of directors (back row) look on as (seated, L to R) RNAO President Carol Timmings, Joshua Tepper, President and CEO of Health Quality Ontario (HQO), RNAO CEO Doris Grinspun and Immediate Past-President Vanessa Burkoski formalize an agreement between the association and HQO to partner on initiatives that reflect the two organizations' common interests in evidence-based practice, quality improvement, and evaluation and measurement. The agreement was signed on Sept. 23.

VIDEO ASKS NURSES TO GET THEIR FLU SHOT

RNAO President Carol Timmings spent some time in a recording studio in September, providing the voice behind a video about the importance of the annual flu shot. The association, with funding from Ontario's Ministry of Health, developed a whiteboard video that takes an evidence-based approach, and encourages nurses to be informed and consider all ways to prevent the flu, including getting the flu shot. Check the RNAO website for details.

NURSING NOTES

Looking back on the life of an exceptional leader

The nursing community is mourning the loss of Dorothy Wylie, an extraordinary leader, former RNAO director, and *Lifetime Achievement Award* winner. Wylie passed away on Aug. 13, 2016, just two days shy of her 87th birthday. The Ryerson University fellow, who also served as a former president of the College of Nurses of Ontario was known for her no-nonsense, get-it-done approach to leadership. In fact, she is described by some as one of nursing's first leaders for her fearless and groundbreaking work to give nurses a voice in the 1970s. Wylie founded the Ontario Provincial Nurse Administrators' Interest Group at that time, which merged with Ontario Nurse Executives in 1998 to become what is now known as RNAO's Nursing Leadership Network of Ontario.

New strategies to care for older adults with delirium, dementia and depression

Nurses encounter older adults with delirium, dementia and depression (3Ds) across all health-care settings. Whether working in primary care, acute care, home care, alternative or complex continuing care, or long-term care, nurses and other interdisciplinary team members now have an improved tool to care for these individuals using evidence-based practices. RNAO's latest best practice guideline (BPG), *Delirium, Dementia, and Depression in Older Adults: Assessment and Care* has replaced the 2010 BPGs on the same subject matter (*Screening for Delirium, Dementia and Depression in Older Adults* and *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression*). Watch for an in-depth feature article about the 3Ds in our next issue of *Registered Nurse Journal.*

All nurses have a role to play in fall prevention initiatives

RNAO has once again joined forces with stakeholders interested in injury prevention to develop and promote activities during Fall Prevention Month in November. This partnership, which was first launched in 2014, is important when you consider, in Ontario alone, 63 older adults are hospitalized each day because of a fall. RNAO released its *Prevention of Falls and Fall Injuries* BPG more than a decade ago. It is currently being revised for re-release in the summer of 2017. While this work on the BPG continues, nurses are being reminded they play an important role in helping to organize events to mark Fall Prevention Month. It could be a social media campaign, a webinar, an exercise class, staff training, or the distribution of posters. For tips on planning an event, visit www.fallpreventionmonth.ca

Support for Fort McMurray nurses

In a show of solidarity and support, members of RNAO's region 7 stepped up and did something special for Alberta nurses directly affected by the wildfires that raged through Fort McMurray earlier this year. In September, gift certificates for pizza lunches for the nurses at the area's local hospital were handed out on behalf of RNAO by Shannon Spenceley, president of the College and Association of Registered Nurses of Alberta (CARNA). The pizzas were ordered through Supreme, a local pizza place that was so impressed by the gesture, it picked up the tax, threw in free drinks, and offered up as many pizza toppings as the nurses wanted. Janet O'Donnell, CARNA's special events co-ordinator, shared with RNAO's region 7 board representative Claudette Holloway that when she talked to two nurses who were former RNAO members, the gesture "…brought tears to their eyes and great pride. All the nurses were touched and asked us to convey their thanks to you." **RN**

OUT OF HA

RM'S WAY

Access to harm reduction programs, including supervised injection services, can save lives.

BY DANIEL PUNCH

PHOTOGRAPHY ETHAN HORST MITCHELL

Leigh Chapman holds a photo from her childhood, and remembers happier times with her brother Brad.

Brad Chapman spent the better part of 20 years on the street, and the majority of that time addicted to drugs.

Smart and resourceful but helplessly dependent on opioids, cocaine and amphetamines, Brad survived by patronizing downtown Toronto's homeless shelters and soup kitchens, and spending the occasional stint in jail. Permanent housing eluded him. At shelters, he sometimes had to worry about being assaulted or having his few possessions stolen. Many nights he made his bed in parks or alleyways.

There are very few constants in the life of a homeless drug user, but Brad found one at The Works, a harm reduction program run by Toronto Public Health. There, he knew he could get clean needles, have dressings changed for his injection wounds, or just talk to someone without being judged. "He felt comfortable there. They really looked after him," says Leigh Chapman, Brad's younger sister.

To say Brad was a regular at The Works would be an understatement. He visited its downtown location for 15 years, often more than once a day. Some nurses remember Brad whipping past on his rollerblades as they made their way to work, his long brown hair flowing behind him. Sometimes he'd ride his rollerblades right into the lobby. Other days he'd walk in quietly and pass out in a chair.

Brad's "harm reduction family" – as Leigh now calls The Works' staff – was often who he called first when he was arrested for loitering or breach of probation, or when he got out of jail, sober and looking for housing. Just like the rest of his family, they watched him fall back into the same habits, and continue the cycle of homelessness and drugs.

As much as he relied on harm reduction services, there was one important rule: it was illegal to use drugs on the premises, just as it is everywhere in Ontario for drug users whose illness is criminalized. If he were in Vancouver, he could have accessed supervised injection services (SIS) and injected drugs in a legal, supervised environment. The same goes for 90 locations throughout western Europe and Australia, where SIS has reduced overdoses, reduced the risk of HIV transmission, and helped drug users into addiction treatment services.

But Brad lived in Ontario, where he was forced to shoot up on the streets. And in the early morning of Aug. 18, 2015, he overdosed in an alley just a few blocks away from The Works, with the program's paraphernalia in his pocket. The 43-year-old father of three and grandfather died in hospital eight days later.

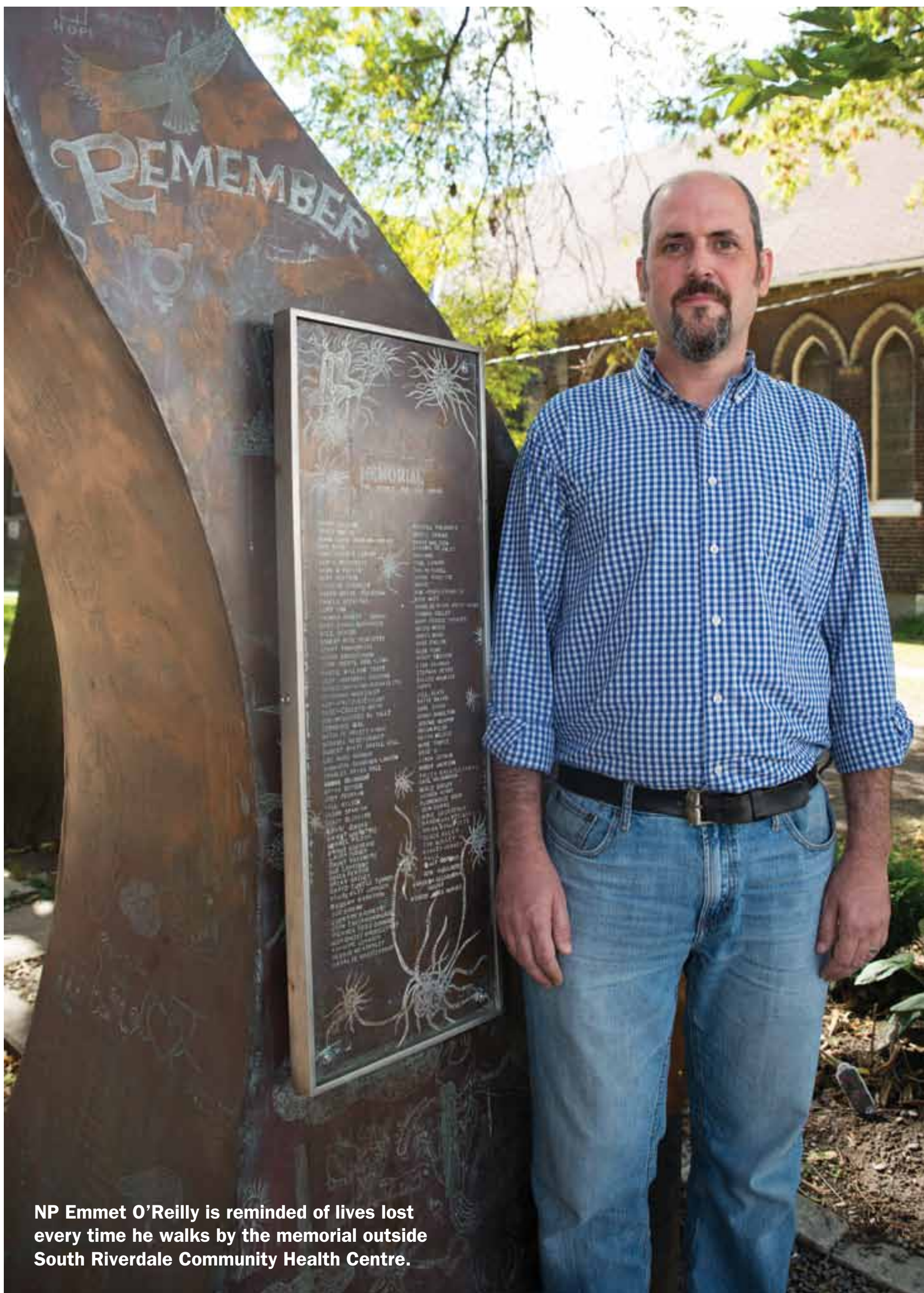
Growing up, Brad was the precocious oldest child of a loving middle class family in Etobicoke. He spoke French, was a natural musician, and played rep hockey. Every summer, the family would travel to Alberta, where Brad would wake up early to catch fish for their breakfast.

But as Brad got older, he started having trouble in school, became isolated from his classmates, and experimented with drugs. Experimentation turned into addiction in his early 20s, after he fell and hurt his back and was prescribed opioid painkillers. When that supply was cut off, he turned to heroin.

Brad's story echoes that of countless others wrapped up in Canada's ongoing opioid crisis. In the face of this public health emergency, many RNs are implementing harm reduction philosophies to save lives and bring people off the streets. Rather than criminalizing people who use drugs, harm reduction looks at the root causes of drug use and how to limit the harm it causes. RNAO has been a strong advocate for expanding harm reduction programs, as have Leigh and her mother Cori Chapman – both nurses.

"There are more successful models of care than expecting drug users to 'just stop using drugs,'" Cori says. "It behooves us all...to care for our most vulnerable populations and to learn about and understand the hardships they face in daily living."

Opioids are a group of powerful drugs that can be highly effective when prescribed for pain, but they are also highly addictive. The amount of opioids prescribed in Canada has increased significantly over the past decade, and a *Globe and Mail* investigation found that doctors gave out 53 opioid prescriptions for every 100 Canadians in 2015. The immense supply of – and demand for – these drugs has also brought prescription opioids onto the black market alongside illicit versions like heroin.



NP Emmet O'Reilly is reminded of lives lost every time he walks by the memorial outside South Riverdale Community Health Centre.

Experts point to a number of factors culminating to create a crisis, including a lack of understanding about addiction and aggressive marketing of opioids by pharmaceutical companies. The result has been a major spike in addiction and overdose. In Ontario alone, more than 6,000 people have died of opioid overdoses since 2000.

Oxycodone was heavily prescribed during the early years of the crisis. To address growing concerns over addiction, it was removed from provincial drug plans in 2012, and its producers altered the drug's formula to make it more difficult to snort and inject. This changed the landscape of the opioid crisis, but did not end it. Many users resorted to heroin. Others found their fix with hydromorphone or fentanyl, which have both been prescribed more frequently since 2012. Overall, the number of opioid prescriptions in Canada has risen 29 per cent since the delisting of oxycodone, while the number of fatal opioid overdoses has increased by 24 per cent. Canadian streets have also been flooded with bootleg fentanyl, which is causing even more overdoses because users often don't know how strong it is.

But harm reduction may be a way forward. Programming comes in many forms, including clean needle exchanges aimed at reducing the spread of infectious disease, and the distribution of naloxone, a drug that can reverse the effects of opioid overdose (see sidebar). Unlike SIS, needle exchanges and naloxone are both currently offered throughout Ontario.

The Dr. Peter Centre in Vancouver broke new ground in 2002 by beginning to offer a health-focused environment for people to inject drugs with the supervision of a nurse. The following year, Insite opened just blocks away as North America's first site dedicated to

PHOTO: ETHAN HORST MITCHELL

providing SIS. Insite operates legally under a federal exemption from drug possession and trafficking laws, but the legality of these services was challenged in 2011 by the Stephen Harper government. Nurses across the country came to Insite's side, and RNAO obtained intervener status to defend SIS when the issue was brought before the Supreme Court of Canada. In September 2011, the Supreme Court ruled in favour of Insite, but the prospect of future legal exemptions for SIS was grim with the federal Conservatives in power.

When the Liberals were elected in 2015, Prime Minister Justin Trudeau expressed his support for SIS. This opened the door for future sites across the country, and a number of municipalities have taken the first steps. So far in 2016, Ottawa's board of health approved a motion to encourage SIS to open in the nation's capital, and feasibility studies for SIS have taken place in Thunder Bay and London. In July 2016, Toronto city council voted 36-3 in favour of a board of health proposal to add SIS to three existing harm reduction programs in the city – The Works, South Riverdale Community Health Centre, and Queen West Central Toronto Community Health Centre. The vote followed public consultation and a number of powerful deputations from stakeholders and advocates. Among them were RNAO CEO Doris Grinspun, and Leigh and Cori Chapman.

SAVING LIVES WITH NALOXONE

Naloxone is a medication that can reverse the effects of opioid overdose, thereby preventing overdose deaths. In June 2016, naloxone kits were made available without a prescription in Ontario pharmacies.

In September, RNAO teamed up with Toronto's Centre for Addiction and Mental Health (CAMH) to provide nurses with more information on naloxone via the webinar *Overdose Prevention and Naloxone: National and Provincial Landscape*. It is archived and is available along with other related resources at RNAO.ca/bpg/initiatives/mhai/video

Health professionals can also learn more about naloxone by calling:

ConnexOntario
24-hour helpline
1-800-565-8603

Ontario Pharmacists Association Opioid Substitution Therapy Drug
Information Line
1-888-519-6069

The Chapmans threw their support behind the proposal after seeing the respect and dignity The Works showed Brad. They also firmly believe Brad would still be alive if he had access to SIS. While it can't bring her brother back, Leigh hopes her advocacy can save others from the same fate. "You don't get a second chance when you overdose, especially if you're alone in an alley," she says.

NP Emmet O'Reilly is reminded of drug users who didn't get a second chance every time he comes to work at South Riverdale Community Health Centre. Outside the building in Toronto's east end is a flame-shaped copper memorial featuring the names of 130 neighbourhood residents who have died as a result of drugs. The statue is sometimes adorned with flowers or cigarette packs left by friends and other South Riverdale clients, and the word "remember" is inscribed at the top. "The number of clients I have on that list is devastating," O'Reilly says. "Those are the people we missed."

Fatal overdoses have jumped 77 per cent in Toronto over the past decade, up to a record 258 in 2014. As one of the three sites pursuing SIS, O'Reilly hopes South Riverdale can significantly reduce that number in the future. Its COUNTERFit harm reduction program is already one of the busiest needle exchange programs in Toronto, distributing nearly 300,000 needles annually, as well as safer crack kits and condoms. The program is already engaged with more than 3,000 drug users, and that's why the health centre was selected for SIS. Studies show people will not travel long distances to inject, so it's important to reach them where they're already receiving services. O'Reilly says SIS will supplement the centre's existing work, and allow harm reduction workers to continue to build trust with clients. "It's not just about preventing overdose, it's about distributing information effectively within the community," he says.

COUNTERFit takes a unique approach to reach its community, relying heavily on peer support workers. It also employs clients who use drugs to operate satellite sites in their homes. With support from harm reduction professionals, they can distribute harm reduction supplies to other users when and where they are needed. It's all part of a philosophy aimed at building therapeutic relationships, meeting clients where they're at, and addressing the social determinants of health. O'Reilly calls it "quintessential nursing," and says that's why nurses must continue to play a crucial role. "When we say 'harm reduction,' the complement to that is risk acceptance – letting people make their own decisions about what risks they're willing to accept in their lives. And that can be difficult for health-care providers...but that's where the trust is built."

Plenty of work remains to bring SIS to Toronto. The federal government still needs to grant legal exemptions and the sites need funding. O'Reilly says it may be 2018 before South Riverdale implements SIS. But once a program is up and running, and people see the sky hasn't fallen, he expects more communities to follow suit.

Residents of Thunder Bay and the surrounding area are dying of overdose at the highest rates in the province.

The city is a hub for northwestern Ontario with a large transient population coming in and out from nearby rural communities, including remote First Nations where opiate addiction has reached epidemic levels. Yet Thunder Bay does not have the same access to services as cities in southern Ontario, which can make tackling the immense need "virtually impossible," says RN Tanelle Rabachuk of Thunder Bay District Health Unit.

Still, Rabachuk and her colleagues are making a difference. The Superior Points harm reduction program she oversees gave out more than one million clean needles to more than 1,200 people in 2015, in a city of just over 100,000. Rabachuk says the success of the program has helped stabilize Thunder Bay's hepatitis C rates – which were once the highest in Ontario – and contributed to the prevention of an outbreak of HIV.

And the city's public health nurses are hopeful they can soon provide more services. Rabachuk is part of the Thunder Bay Drug

ADDRESSING HOMELESSNESS AT ITS ROOTS

For Brad Chapman, drug addiction was closely linked with homelessness. His story is not unique. In fact, some experts say that mitigating the harm caused by drugs means having a frank discussion about keeping people off the street. In order to do that, nursing professor and researcher Cheryl Forchuk says it's crucial to address the circumstances that lead to homelessness.

Forchuk, an active RNAO member, was part of the Expert Advisory Panel on Homelessness which the Ontario government tasked with examining the next phase of its poverty reduction strategy. The panel was co-chaired by Deputy Premier Deb Matthews and Minister of Municipal Affairs and Housing Ted McMeekin. The panel released its report in October 2015, and the government committed to implementing many of its recommendations, including setting a target to end chronic homelessness within 10 years.

Forchuk applauds the government's commitment to tackle homelessness,which sometimes occurs following transition from provincially funded institutions. She has studied how patients can end up homeless after discharge from hospital, and says patients are often released from acute care without adequate housing. "That ends up being a pipeline into homelessness," she says.

Nurses can help address this by thoroughly assessing a patient's housing situation, and not just relying on the address written on an intake form. If nurses see someone is about to be discharged without proper housing in place, she insists they speak up.

"If we are really paying attention to the social determinants of health, we should be having discussions about housing with everyone we're seeing," Forchuk says.

Read the panel's full report by visiting mah.gov.on.ca and searching for *A Place To Call Home*.

Strategy, which is supporting a feasibility study looking into bringing SIS to the community. The study, conducted by a pair of B.C. HIV researchers, interviewed injection drug users and other community members in Thunder Bay and London to determine if SIS is a good strategy for their cities. The results are due out this fall. "There has been so much research on SIS and the lives that are changed (by it)," Rabachuk says. "I'm pretty excited about the possibility of having that service here."

As for London, nurses are hoping SIS could potentially curb a growing HIV crisis in their city. The number of HIV infections in that city has grown by more than 50 per cent in the past decade, despite dropping province-wide over that same period. More than two thirds of new infections are related to injection drug use, says Shaya Dhinsa, a nurse manager at the local health unit. "People are participating in unsafe injection practices. They're sharing or reusing," Dhinsa says. "SIS could provide an opportunity to access clean needles, inject safely, and be connected to health services that might benefit our city."

A lot has changed in the year since Brad passed away.

In addition to the progress toward SIS, naloxone has been made available in Ontario pharmacies at no cost and without a prescription. With training from a pharmacist, people at risk of overdose, and those around them, can now more easily access the life-saving drug. In May, the provincial coroner's office said it was looking into ways to better track the deaths of homeless Ontarians. Brad's story, as profiled in the *Toronto Star*, helped bring to light the lack of a co-ordinated approach to recording homeless deaths, leaving gaps in the province's ability to understand and address homelessness.

Leigh, too, has changed significantly. She never used to talk about having a brother who was a homeless drug user, fearing it would affect the way people looked at her. She has since learned the power of telling Brad's story. "That stigma is actually what kills people – not talking about overdose, not talking about drug use," she says. "The more we talk about it, the more we raise awareness, the less people will die."

From a nursing perspective, she is struck by how little attention overdose gets, despite being among the deadliest possible health conditions. "Nurses should be appalled (fatal overdose) is happening and feel compelled to act," she says.

One of Leigh's biggest epiphanies over the past year was about the uphill battle faced by drug users and homeless people. The public is sometimes quick to write them off, saying adequate services exist if people choose to use them. But Leigh's brother was a survivor. Brad was a man who did his own wound care, boasting to nurses at The Works that he learned the skills from his nurse mother. He was active and resourceful in accessing services, yet he still slept on the street and died of a drug overdose. Leigh wonders what more we can ask of people.

"I just think people shouldn't die like this (and) I wish Brad didn't die like this," she says, pausing regularly to take a breath and quell her emotion. "There are more Brads. They're brothers, they're sisters, they're fathers. They're leaving behind people who care about them, and they're leaving much too soon." **RN**

DANIEL PUNCH IS STAFF WRITER FOR RNAO.

PHOTO: ISTOCKPHOTO.COM/MONKEYBUSINESSIMAGES

George Fieber (left) nominated his Thunder Bay colleague Melanie Cates (right) for an RNAO Recognition Award.

A moment to shine

While much of the hard work of members remains under the radar, RNAO's annual recognition awards provide an opportunity to shine the spotlight on those who go above and beyond.

BY DANIEL PUNCH

Melanie Cates quietly approaches the stage at RNAO's 2016 annual general meeting (AGM) to accept the Leadership Award in Nursing Education (Staff Development).

The crowd of nurses assembled for the event gives her a round of applause, and CEO Doris Grinspun is waiting on stage with a congratulatory hug. Cates is handed her plaque by outgoing RNAO President Vanessa Burkoski and flashes a humble smile as she steps up to the microphone.

With her unassuming demeanor, she looks as though she'd be more comfortable back at Thunder Bay Regional Health Sciences Centre (TBRHSC) – where she is professional practice leader – than in the spotlight.

"I am overwhelmed and very honoured to have received this award," she tells the room full of her peers, her gold RN pin displayed proudly on an off-white blazer. She thanks her colleague George Fieber for the nomination.

Nurses often don't think there is anything special or award-worthy about them doing their job... These awards give us a chance to recognize these people for all the work they do.

– DENISE WOOD

"When I found out I won the award, I looked at George and said, 'oh dear, what did you say about me? What do I have to live up to?'" she recalls, sparking a laugh from the audience.

One look at Cates' extensive resume proves she has already lived up to the honour of an RNAO Recognition Award. Her efforts to train and mentor TBRHSC staff, host best practice champion workshops for the Lakehead chapter, and countless other accomplishments show her dedication to nursing excellence. But the honour came as a complete surprise.

And that's what makes these awards so important, says membership recruitment and retention committee (MMRC) chair Denise Wood. The MMRC, which oversees the awards and selects winners, relishes the opportunity to celebrate nurses like Cates, who quietly make an enormous impact.

"Nurses often don't think there is anything special or award-worthy about them doing their job," Wood, an RNAO board member, says. "These awards give us a chance to recognize these people for all the work they do."

Since 1993, RNAO has handed out its annual recognition awards to members who excel in various aspects of nursing practice, education, research, administration and policy. The list of winners includes everyone from front-line staff to upper management, from long-serving and decorated RNs and NPs to fresh-faced nursing students. The awards also acknowledge outstanding chapters, regions and interest groups for their contributions to nursing, health care and RNAO. The competition has grown over the years, from just four prizes in 2003 to the 18 that could be handed out in 2017 (see sidebar for more on the award categories).

It's a prestigious honour, but at its heart, the awards program is a grassroots competition driven by colleagues. Any RNAO member can nominate an RN, NP, nursing student, chapter, region or interest group for an award, and the nominations are judged by nursing peers on the MMRC (comprised of three RNAO board members and five general members). The process is simple: nominators log onto their *MyRNAO* account once the competition opens in the fall, and fill out the nomination forms under the *Inside Your Association* tab before the January deadline.

"It's easy. You don't have to have a PhD to nominate someone," Wood jokes.

Thanks to the hard work of the MMRC, the nomination process is easier than ever. This year, the committee revamped each award and based the new criteria around RNAO's strategic directions and its ENDs – directives that guide all facets of RNAO's work to advance the nursing profession and improve the health of Ontarians and their health system. Wood says the changes will ensure clarity and consistency for the nominators, who must describe, with specific examples, and in some cases provide supporting documentation, how their nominee meets the four ENDs (see the ENDS at RNAO.ca/about/mission).

The nominations are compiled and sent to the selection committee who carefully consider each submission and score them, but not before the names, locations, and organizations are blacked out to eliminate any potential conflict of interest. The judges' scores are tabulated by home office staff, and the winners are notified in February. It's a major undertaking for the MMRC and for RNAO's membership department, but long-time committee member Aric Rankin considers himself lucky to be able to read about the diverse impact RNAO members are having on their patients and on the health system.

So what makes a recognition award nominee stand out?

"I'm looking for someone who is well-rounded and really involved not just in their organization, but in the community as a whole," says Rankin, who is also an RNAO board member.

He says it also helps when a nomination is written in creative and easy-to-read language. Thus it's important to take your time, and

not rush the process. Be sure to proof-read to avoid any errors or typos that might distract from the nominee's accomplishments, he says. "The (nominations) that stand out are the ones that provide multiple examples, and tie them together beautifully."

Wood agrees that a truly special nomination is about more than just the hard facts.

"I like to see people speak from their heart," she says. "If the nominator really knows the (nominee), then they're able to draw on their personal and professional qualities and put them in the submission."

MMRC member Paul-André Gauthier advises nominators not to be vague – be sure to explicitly detail their subject's contributions to the nursing profession. Do they go above and beyond the call of duty? Do they show leadership? Do they inspire others around them?

But before answering these questions, members must open their eyes to the outstanding nurses they work with every day, Gauthier says.

"Look to the nurses around you. Some of them need to be recognized because they are exemplary models for our colleagues and the nursing profession, but they're doing work under the radar."

A 2015 Lifetime Achievement Award recipient, Gauthier has experienced the competition from both sides. He says being recognized by his peers was an emotional experience, and people are constantly impressed when he tells them about the prestigious honour.

The competition culminates in the spring when winners receive their awards at the AGM. After putting in so much hard work with the MMRC throughout the year, Wood says her reward comes from seeing the smiles on the winners' faces.

"When people get an award, they're blown away," she says. "They bring their family...and it's just amazing. I want nurses across the province to feel the same way."

Rankin thinks every RNAO member should consider nominating a colleague.

"There are so many members out there doing wonderful things (and) often times nurses are quite humble and don't talk about their achievements," Rankin says. "It's always exciting to see their response when they've been nominated, and when they actually win an award, it's special to see them shine in that moment."

And that moment is special for anyone, even for nurses whose presence at RNAO has been a bit more visible to the broader membership. In 2016, Una Ferguson won the Leadership Award in Political Action. Ferguson is a household name around RNAO, and has served two terms on the association's board of directors. She is also a regular at Queen's Park Day, Queen's Park on the Road, and Take Your MPP to Work, and has been a driving force in Region 10 – one of the association's most active regions. Her nominators for this award boasted about how Ferguson launched the region's annual Breakfast with Politicians (now in its 14th year), and how she has become a "well-respected role model" for her peers. But despite all her accomplishments, she was still moved as she addressed the AGM crowd to accept her recognition award.

"I never ever expected to win an award like this," she said, her voice quivering with emotion as she reflected on her "16-year adventure" as a member. "I'm honoured and proud to be associated with this RNAO family." **RN**

DANIEL PUNCH IS STAFF WRITER FOR RNAO.

Celebrate the outstanding achievements of nurses

Nominate a colleague, your chapter, interest group, or your organization for one of the following awards for presentation at RNAO's 2017 AGM…

- Workplace Liaison Award
- Leadership Award in Nursing Administration
- Leadership Award in Nursing Education (Academic)
- Leadership Award in Nursing Education (Staff Development)
- Leadership Award in Nursing Research
- Leadership Award in Political Action
- Leadership Award in BPG Implementation
- Chapter of the Year Award
- Interest Group of the Year Award
- RNAO Promotion in a Nursing Program Award
- Leadership Award in Student Mentorship
- Student of Distinction Award
- Lifetime Achievement Award
- Honoured Friend of Nursing
- Award of Merit
- RNAO in the Workplace Award
- HUB Fellowship (self-nominations welcome)
- President's Award for Leadership in Clinical Nursing Practice (self-nominations welcome)

Deadline for nominations: Jan. 6, 2017

For more details and nomination forms, sign in to myRNAO.ca/inside-RNAO

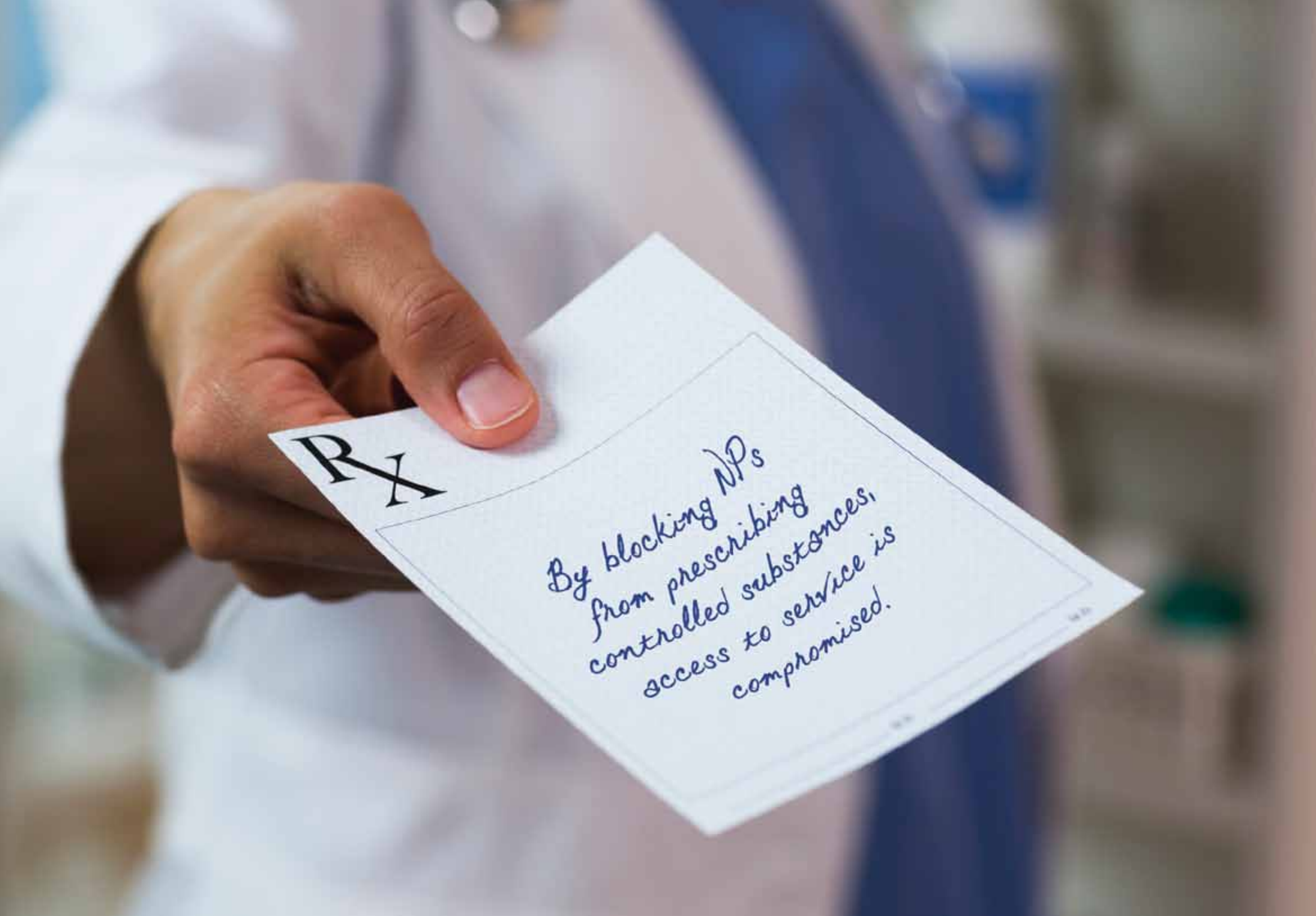


PHOTO: ISTOCKPHOTO.COM/ STEVECOLEIMAGES

Scope of practice limited for Ontario NPs

Ontario is the only jurisdiction in Canada where NPs cannot prescribe controlled substances.

BY DANIEL PUNCH

David Free knew just what his dying patient needed. He needed a breakthrough dose of an opioid to relieve the intense pain caused by his terminal cancer. It was the same medication and dosage the man received earlier that day, and the same medication Free had prescribed numerous times for other patients as an NP practising in Maryland.

But this wasn't Maryland. It was Ontario. And unlike in Maryland, and nearly every other jurisdiction in North America, Ontario NPs cannot prescribe opioids.

"I knew exactly what needed to be done, but I was restricted to having to get a verbal order from a physician to be able to do it," Free recalls.

Instead of easing his dying patient's pain, Free spent the next hour trying to track down a physician to prescribe some relief. He couldn't, and the patient suffered needlessly for nearly 90 minutes in the waning hours of his life until his next scheduled dose was due.

Despite being able to prescribe most medications, Canadian NPs were long prohibited from prescribing drugs listed in the federal *Controlled Drugs and Substances Act*, including opioids and benzodiazepines.

That all changed in 2012, when amendments to the *Act* gave NPs the authority to prescribe controlled substances. Provinces and territories needed only to alter their regulations to expand NPs' scope, which all of them have done since – all except Ontario.

When Free heard there were changes coming to the *Controlled Drugs and Substances Act*, he was working in the United States. The Ontario native had moved south of the border in 2009 to take the

NP program at the University of Maryland at Baltimore. As an NP in Maryland, he practised to his full scope, prescribing opioids and other controlled substances to his palliative care patients.

After completing his clinical doctorate, he moved back to Ontario in 2015 to become director of palliative care at a large hospital system, expecting he would soon be able to prescribe controlled substances in his home province. Instead, he has been frustrated by his inability to prescribe the pain medication his patients require. "It feels like it really cuts me off at the knees," he says.

RNAO has worked for years to get Ontario NPs authorized to prescribe controlled substances. There are more than 2,600 NPs registered in the province, and they are already able to diagnose, order and interpret diagnostic tests, and prescribe medications – but not everything their patients need. Since the 2012 federal legislative changes, RNAO has advocated for regulatory amendments to Ontario's *Nursing Act, 1991* to eliminate the restriction on NPs prescribing controlled substances. Yet nearly four years later, Ontario has fallen behind.

"The lack of progress in Ontario is alarming. There is an urgent need to accelerate provincial regulatory changes," RNAO CEO Doris Grinspun wrote in a recent letter to Health Minister Eric Hoskins.

Back in 2014, the College of Nurses of Ontario (CNO) drafted practice standards which included NPs prescribing, dispensing, administering and managing controlled substances. RNAO provided feedback and was largely supportive of the document. But CNO's 2016 draft practice standards state explicitly that NPs must not prescribe controlled substances. In its response to the draft standards, RNAO listed this restriction as a significant practice barrier for NPs, and urged swift changes.

"The misuse and abuse of controlled substances have become a major public health challenge for governments," CNO said in the August 2016 issue of its magazine, *The Standard*. "Given the complexities, regulation change enabling NPs to prescribe controlled substances will be made following policy direction from, and in close collaboration with, the Ontario government."

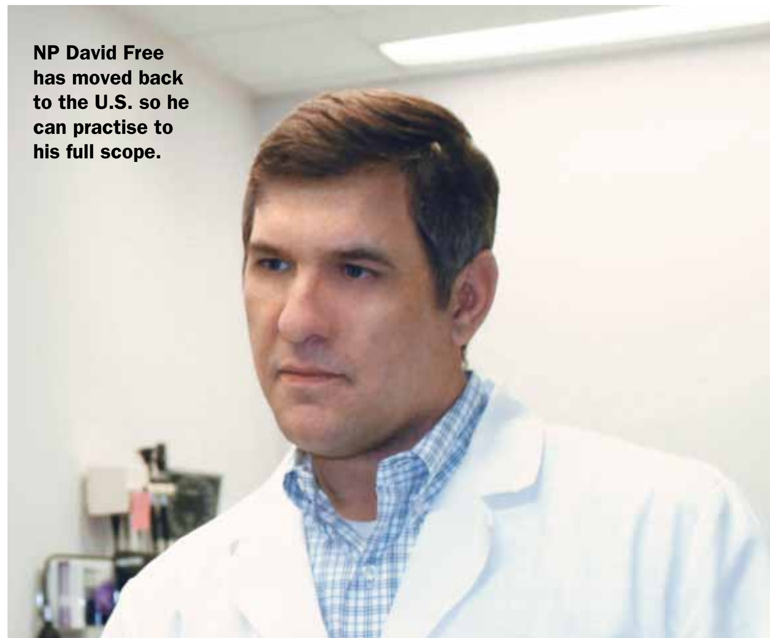
Asked why Ontario has yet to move forward, Health Ministry spokesperson David Jensen said prescribing controlled substances is a significant responsibility. "The ministry will need to ensure that the public is protected and that providers are competent to provide this service." Recently, and in response to RNAO's pressure, ministry officials have indicated the government plans to enable NPs to prescribe controlled drugs.

While NPs wait for news on this front, their responsibilities have grown. *Bill C-14* was passed earlier this year, giving NPs the authority to provide medical assistance in dying. This would require them to prescribe controlled substances currently outside of their scope. Jensen acknowledged a regulatory change is needed in order to allow NPs to fully participate in assisted dying, and said the ministry will work with CNO to make it a reality.

But why are changes taking so long?

Free says he doesn't know, but he suspects it's partly because of concerns around the province's rising rates of opioid addiction. Ontario has seen a 72 per cent increase in the number of hospital visits for opioid overdose in the past decade, and some experts say the problem is largely due to overprescribing. One study published in *Canadian Family Physician* found Ontario dispensed oxycodone and fentanyl at the highest rates in the country.

But Free says any concerns that having more prescribers would lead to more opioids being prescribed are misguided. If opioids have been prescribed excessively to date, NPs have played no part in it. And there is no evidence to suggest NPs will prescribe any more than physicians do.



NP David Free has moved back to the U.S. so he can practise to his full scope.

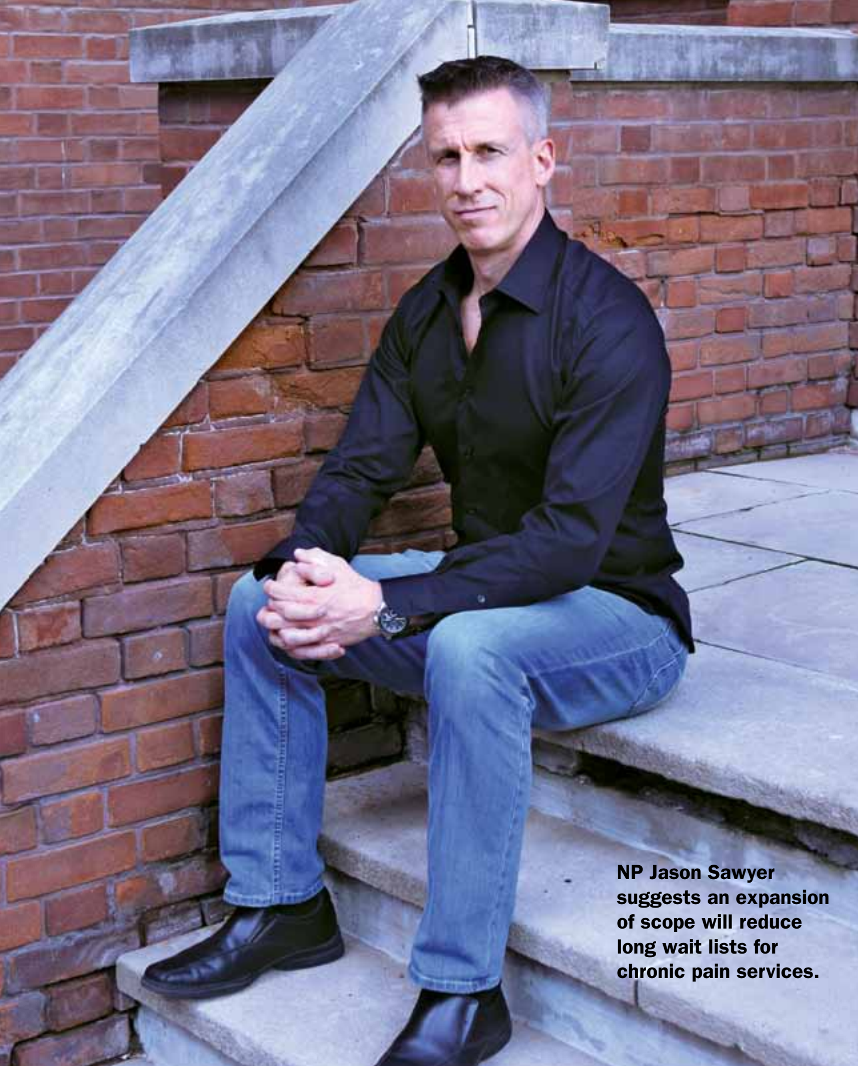
> "I knew exactly what needed to be done, but I was restricted to having to get a verbal order from a physician to be able to do it."
>
> **– DAVID FREE**

"Has there been any substantial rises (in opioid prescription) in the last four years in the provinces and territories where NPs are prescribing controlled substances? No," Free says.

NP Jason Sawyer says he and his colleagues may even be able to curb the use of opioids. He specializes in acute pain services at Sunnybrook Health Sciences Centre, where he encounters patients taking controlled substances every day. While he can't prescribe himself, he says he is lucky to work with physicians who trust his assessments, allowing him to provide patients with the right amount of pain medication – which is often less than they were on when they came into hospital.

He recently worked with a 42-year-old woman who spent much of the last two decades on opioids. After nearly 40 surgeries for various chronic ailments, she was taking 300 mg of hydromorphone per day via a subcutaneous infusion pump. Sawyer built a rapport with the woman during many hospitalizations over the course of a decade, including a two-month stay following surgery earlier this year. Together, they determined she may not need all the medication she was on. Through a slow weaning process, Sawyer helped her get off opioids completely without any withdrawal symptoms.

"Prescribing is not just about giving people more opioids. In



NP Jason Sawyer suggests an expansion of scope will reduce long wait lists for chronic pain services.

> “If NPs can prescribe opioids... maybe our greatest impact (will be) not creating the next generation of addicts.”
>
> – JASON SAWYER

many cases, it’s about giving them less,” he says. “If NPs can prescribe opioids...maybe our greatest impact (will be) not creating the next generation of addicts.”

Sawyer has worked in pain management for 15 years, and is on the board of directors for the American Society for Pain Management Nursing. He sees the expansion of NP scope in Ontario as an opportunity to reduce the sometimes two-year backlog of patients seeking chronic pain services in the province. “What would it be like if there were 2,600 more people who had the autonomy and accountability to manage their pain?” he asks.

While much of the discussion around controlled substances focuses on pain management and palliative care, an expanded scope would free up NP Erin Ziegler to help a different population. She works at Brampton’s Wise Elephant Family Health Team (FHT), which is one of the only clinics in the Central West LHIN accepting patients to do work-up and assessment for transgender hormones. Of the 40 or so transgender patients on the FHT’s roster, more than half are transgender males either taking testosterone as part of transitional hormone therapy, or planning to start.

As an NP, Ziegler performs hormone readiness assessments and monitors blood work for patients on testosterone. But when it comes time to prescribe testosterone or adjust dosage, she must wait to consult with a physician, because testosterone is a controlled substance.

Transgender people have historically had a difficult time finding primary care providers who understand trans issues, and are sometimes turned down by physicians. A number of NPs have stepped up to fill the void, but are hindered by their inability to prescribe testosterone. It’s yet another barrier to accessing care for transgender people, and risks further alienating them from the health system. “(Transgender people) are at a very vulnerable time when they’re making the decision to transition,” Ziegler says. “They’re at risk for depression and all the things that go along with (that).”

Ziegler has worked with patients who, when they had trouble accessing testosterone through a health care provider in the past, resorted to buying it over the internet and administering it themselves. This can be very dangerous without the proper consultation, monitoring, and sterile supplies. She recalls one patient who used to order testosterone from Asia and pick it up in the U.S., thus becoming a criminal when he brought the controlled substance back over the border. “It broke my heart that’s what he had to resort to just to get medical care in Canada,” she says.

And if patients coming to Ziegler’s urban FHT can run into roadblocks accessing testosterone, then she says transgender patients in rural and remote areas of the province – where physicians are not always available – would run into a “dead end.”

Free says the same is true for palliative patients outside of urban areas, and that flies in the face of the government’s stated commitment to improve access. A 2013 British Columbia study found that giving NPs the authority to prescribe controlled substances could provide “more equitable access to care for clients who live in rural and remote communities.” This sentiment was echoed by RNAO in a letter to Health Minister Eric Hoskins, which noted expanding NPs’ scope could improve indigenous health, LGBTQ health, and access to primary and end-of-life care. “By preventing NPs from prescribing (controlled substances), they’re preventing access to service,” Free says.

And by limiting NPs’ scope, they risk alienating these highly trained professionals.

Free recently took leave from his job in Niagara to care for an ailing family member in North Carolina. While there, he was offered a job as director at a large hospice organization. It was an opportunity to once again use the full range of his expertise, and he took it. “If we want to recruit and retain good people (in Ontario), we have to make the environment such that they can practise to the full extent of their scope,” he says. **RN**

DANIEL PUNCH IS STAFF WRITER FOR RNAO.

PHOTO: DANIEL PUNCH, RNAO

POLICY AT WORK

Deputy Health Minister Bob Bell (centre) speaks to RNAO's board of directors on Sept. 23.

Deputy health minister pays a visit to RNAO

Bob Bell, Ontario's deputy health minister visited RNAO's home office on Sept. 23 to speak with members of the association's board of directors about a number of key priorities. During an hour-long exchange, he thanked the association for the advice it provided on health system change and acknowledged much of what RNAO recommended in its *Enhancing Community Care for Ontarians (ECCO)* report was borrowed and used in the government's *Patients First* legislation. The board welcomed Bell's announcement that RNAO CEO Doris Grinspun has been asked to join a task force that will oversee implementation of the legislation.

When urged about the government's promise to better compensate NPs working in primary care, Bell said the money will soon flow, and that it will be retroactive to April 1, 2016. He also confirmed the ministry is moving ahead with independent RN prescribing. Bell agreed with RNAO's board that patients with acute care needs demanding the expertise of tertiary or quaternary hospitals require RN care, including cancer patients. One of the key recommendations in the association's *Mind the Safety Gap* report calls for all-RN staffing in tertiary and quaternary hospitals.

Proposed practice changes for RNs, NPs

The Ontario government is moving ahead with a promise to authorize RNs to complete medical certificates of death (MCD), an issue raised repeatedly by RNAO. Under the proposed changes, RNs can complete MCDs if: the RN had a nurse-patient relationship with the deceased; the death was expected; there was a documented medical diagnosis of a terminal disease; and/or there was a predictable pattern of decline for the deceased.

MCDs are requested by funeral directors before transporting a deceased person's body. Giving RNs the authority to perform this function will provide families and caregivers with dignity and peace of mind. In its response to the proposed change, RNAO has expressed concerns, however, that RNs can only complete MCDs if the death is the result of a diagnosed terminal disease, arguing the stipulation is unnecessarily restrictive and reduces the RN's role as a health provider. The association wants to see the specific criterion for a "medical diagnosis of a terminal disease" removed. NPs are able to certify death. However, those same conditions restrict their ability to complete the forms. For more information, read RNAO's submission at RNAO.ca/MCD

Personal emergency leave

RNAO recently had the chance to weigh in on proposed changes to Ontario's labour laws. The association agrees with a recommendation in the *Changing Workplaces Review Special Advisors' Interim Report* that would provide all workers with access to 10 days of unpaid personal emergency leave (PEL) regardless of the size of the employer. Currently, only companies with 50 or more employees are required to provide such leave. In its response letter to the Ministry of Labour, RNAO stated that providing PEL ensures basic fairness among workers and sets a minimum standard for decency in the workplace. Unpaid leave allows employees to take care of personal matters, including the health needs of family members. RNAO says having the flexibility to rely on PEL is more important than ever given the province's aging population and the growing number of women in the workforce.

Shaping healthy public policy

RNAO is inviting members to meet with members of provincial parliament (MPP) as part of *Queen's Park on the Road* (QPOR). Now in its fourth year, the initiative brings RNs, NPs, nursing students, and politicians together to talk about health, health care, and nursing policy. The association has invited all 105 sitting MPPs to meet with RNAO members in their local constituency offices. The meetings provide nurses with a forum to share first-hand experiences and the solutions RNAO believes will improve patient and client care, and health system effectiveness.

Members are encouraged to bring up issues specific to their region, and to also help push key RNAO priorities such as: ensuring RNs and NPs are working to their full and expanded scopes of practice; promoting the need for supervised injection services; and advocating for Ontario workers to receive access to paid sick days, among other issues. RNAO's policy department has created a series of briefing notes to prepare members for their meetings.

Anyone interested in taking part, or finding out more, can visit QPOR.RNAO.ca **RN**

RNs in the COURTROOM

Whether acting as juror or witness at a coroner's inquest, nurses play a vital role in the analysis of evidence and creation of recommendations that help build stronger health and social systems.

BY KIMBERLEY KEARSEY

Laura Jackson put her life on hold for five months to be a juror at the Katelynn Sampson coroner's inquest.

Like hundreds of other Ontarians summoned by the Ministry of the Attorney General for jury selection, RN Laura Jackson wasn't quite sure what to expect when she arrived at Toronto's Superior Court of Justice in the fall of 2015. She never gave much thought to the possibility of being selected as a juror, nor did she know much about the troubled life and tragic death of a little girl named Katelynn Sampson. Over the next five months, as one of five jurors at a coroner's inquest into the young girl's murder, Jackson would put her life on hold to examine how the girl slipped through the cracks and died in 2008.

"It had such a huge impact on my life," the mental health nurse says of her role as a juror, and her introduction to Sampson. "I think the first day in court we heard the 911 tape...a few days in, we heard from the forensic pathologist and saw the images of Katelynn. Seven years old and she had about 70 wounds on her body. Those images are still in my head."

PHOTO: STEFANIE NEVES

Sampson's biological mother, who struggled with addiction, signed an informal agreement in 2007 to hand over legal guardianship of her daughter to her friends Donna Irving and Warren Johnson. The pair would later plead guilty to beating her to death, and are now in prison. Irving called the Children's Aid Society asking to have the girl removed from their care just months before her death. Because Irving is half-Anishinabe, her call was passed along to Native Child and Family Services, creating another layer between Sampson and the support she needed from the systems set up to help her. The warning signs leading up to that call – and following it – were glaring. Worried school officials called Children's Aid, but no action was taken.

Jackson hopes talking about her experience will get nurses thinking about child welfare and child and adolescent health. She wants to raise awareness that will lead to changes that ensure greater accountability for agencies charged with child safety. The recommendations of a coroner's inquest can lead to important modifications in policy and legislation, and Jackson is hopeful that will happen with at least some of the 173 recommendations she helped to develop when the Sampson inquest wrapped up this past April.

The importance of advocating for children is the central lesson the 38-year-old RN says she's taken away from her experience as a juror. In fact, that is the basis for the jury's first and most important recommendation known as Katelynn's Principle; the notion that every child be seen, heard and respected when it comes to any and all decisions about their care. Sadly, Sampson was not at the centre of her care. She was "ignored," Jackson says of the repeated cries for help that went unheard in her case. "I think that was the biggest lesson for me."

Jackson is proud of her work as a juror, particularly with regards to the recommendations and the energy that went into creating them. "This (inquest) was a huge chunk of my life," she says. "And it was not easy. We got close to 400 exhibits...there were 13,000 pages of disclosure...we had to sit through days and days of evidence." She says they set a record for the amount of time it took to deliberate, but reflects back that there was no way they could have combed through all of the information in less time. "It had a huge impact on all of us and we wanted to get through it, but we also wanted to do it right. We had to make sure we understood everything."

The experience was emotionally exhausting, Jackson adds, but "I'm glad I did it."

"I think I'm a better clinician because of this experience," she adds.

Did her nursing expertise come into play as a juror? "I definitely think so," Jackson speculates, especially given the issues of accountability and standards as they relate to the agencies that should have been paying more attention to Sampson. As an RN, Jackson understands accountability and knows the skill that goes into assessing people in need. That "...was absolutely useful," she says, but stops short of suggesting her RN status had any direct bearing on the jury's recommendations, since those are based entirely on the evidence presented in court. "You have to go through the inquest process with that neutrality," she explains. You have to "go in with an open mind and let the evidence speak."

The role Jackson played in the Sampson inquest is unique because her nursing background wasn't a factor in her selection as a juror. Nursing background and skill comes into play far more often when RNs are involved in inquests as witnesses. This happens if the death of a patient is being investigated, and if the nurses involved in that patient's care have information that will help in the investigation. "If you have knowledge of (the circumstances surrounding a death), you can be subpoenaed to attend," explains Tim Hannigan, a lawyer for RNAO who has helped members through the inquest process.

> Being a juror was emotionally exhausting, but: "I'm glad I did it. I think I'm a better clinician because of this experience." – LAURA JACKSON

Although the roles of juror and witness are equally important to the legal process, the latter is often associated with far more pressure and anxiety around what it means on a professional level.

"Anyone getting pulled into something like this is understandably nervous about it, and what the implications of it might be," explains Hannigan. He eases some of that concern by clarifying a coroner's inquest is not designed to lay blame. "It should not have a result that nurse A or nurse B is responsible," he says. In fact: "If the jury were to try to assign blame, the coroner would not accept that."

Dig a bit deeper and Hannigan does warn nurses that there may be implications from an inquest that affect them down the road. "Depending on how the evidence unfolds, there may be red flags raised about the behaviour of certain people involved. From the perspective of, say, a family...if they have a civil suit...(the evidence given at an inquest) may mean they double their focus on a particular person. (The inquest) may influence how the civil suit proceeds."

Hannigan's advice to nurses in this regard: "Approach everything as if it's as serious as something that could be the focus of a coroner's inquest. Always document as if you are one day going to be on the stand testifying about it."

Having led a number of seminars on what to expect at inquests, and seeing first-hand what nurses go through in the courtroom, Hannigan agrees it's not easy. "At a coroner's inquest, you might have five to 10 different lawyers there, all representing different interests, and all of whom would have an opportunity to cross examine a witness. It can be very intimidating to go through this process," he explains.

RNAO IN THE COURTROOM

While nurses can be called upon to provide witness testimony at an inquest or inquiry, RNAO can request 'standing' and provide expert testimony if it determines its involvement is in the best interest of the nursing profession and/or the health system. Here are two examples that illustrate how RNAO's perspective in the courtroom led to important changes for nurses and patients.

CORONER'S INQUEST

A public hearing conducted by a coroner (a physician with specialized training in the principles of death investigation) before a jury of five community members.

Jeffrey James was a patient at Toronto's Centre for Addiction and Mental Health in 2005. He was placed in restraints after he was seen engaging in a sex act while standing near the nursing station. A nurse who witnessed the incident told him to stop and go back to his room, but he refused and a struggle ensued. For the next five days, James was placed in restraints, and when he was released, he collapsed to the floor and later died from an acute pulmonary thromboembolism. A coroner's inquest was called into his death in 2008. RNAO was granted standing at the inquest to provide testimony on systemic problems with nurse staffing, and the need for continuity of care and caregiver. RNAO also recommended best practices and education on a least-restraints approach to nursing practice. When the inquest wrapped up, the jury released recommendations related to staffing and guidelines on the use of restraints. That recommendation led to the creation of RNAO's *Promoting Safety: Alternative Approaches to the use of restraints* BPG in 2012.

ROYAL COMMISSION OF INQUIRY

An investigation of national importance (launched at the federal level) led by experts or judges who have the power to subpoena witnesses and take evidence under oath.

During a nine-month period from July 1, 1980 to March 22, 1981, there were 36 deaths on Wards 4A and 4B (cardiology) at Toronto's Hospital for Sick Children. RN Susan Nelles was charged with murder in four of those deaths. A preliminary hearing in 1982 found there was insufficient evidence to commit Nelles to trial. In 1983, a Royal Commission of Inquiry (known as the Grange Inquiry) was called. Nursing practice was placed under a microscope and a number of RNAO members, with support from the association, testified. The inquiry, which many described as a witch hunt for its focus on nurses and no other health professionals, set in motion a wave of concern about how RNs can best protect themselves if they encounter legal difficulties as a result of their practice. Historically, nurses were encouraged to accept legal representation from their employers. However, the Grange Inquiry brought to light the interests of nurses are sometimes different from those of their employer. RNAO heeded the concerns of its members about fair representation, and launched the Legal Assistance Program (LAP) in 1986. To date, thousands of RNs and NPs have received legal representation through LAP.

Then RNAO President Wendy Fucile (left) leaves coroners courts after testifying at the Jeffrey James inquest in 2008.

PHOTO: KIMBERLEY KEARSEY, RNAO

Wendy Fucile, RNAO past president and a nursing instructor at Trent University, has been in a number of leadership roles in the acute care setting and has provided testimony at several inquests related to workplace incidents involving the death of a patient. "I think coroner's inquests are an incredibly important part of our system. It's a privilege – maybe a bit scary, but still a privilege – to be able to be part of trying to make it better. That's how I come at (testifying) every time."

That said, some inquests are certainly harder than others, Fucile admits. Looking back to the 90s, when she was a witness at an inquest into the death of an elderly patient in Peterborough who had survived a car crash, but later died from an enlarged bowel that nobody caught, Fucile recalls "...it was...as is every inquest I've been to...an incredibly sad moment. You have family that has lost someone. You have a life that is gone. Even though an inquest isn't about laying blame...you always have staff who are second-guessing themselves and feeling a whole gamut of emotions. It is a difficult time for everyone in the process."

Fucile is well aware of the challenges frontline nurses face in the courtroom. An RN who was directly involved with the patient who died will approach an inquest from a very personal place. "If you feel uncomfortable...it's easy to get stampeded into answering things. And it does feel scary." She has some advice for nurses who find themselves in that situation. "You're not up there telling *War and Peace*. Only answer what they ask you, and answer it briefly and concisely."

As a nursing instructor, Fucile has discussed her experience at inquests with first-year students who are often shocked that a nurse can be called upon to testify. It's important that they realize this is a real possibility for any RN, she says. The classroom is a place to discuss all aspects of health care, including the need for a culture of safety. "The role of a coroner's inquest is to improve safety. It's important...to understand what a coroner's inquest is."

It's also important that the nursing perspective has been heard during legal proceedings. Fucile was called upon as president of RNAO to provide testimony at the investigation into the 2005 death of Jeffrey James, a patient at Toronto's Centre for Addiction and Mental Health. James was restrained for five days and died after being released from those restraints (see sidebar for more on this). RNAO requested standing at the inquest in 2008 because of the significance the investigation had to the nursing profession in a

broad sense. With its system expertise, and its well-established and internationally respected process around the development of best practices, RNAO felt it could come forward and suggest there were systemic issues of staffing, especially around continuity of care and caregiver. In addition, RNAO wanted to suggest it could source evidence and create a tool that could be used to improve the safety of patients.

"Nurses as knowledge workers have a viewpoint and perspective to bring to the discussion," Fucile says about the reasoning behind RNAO's standing at that particular inquest.

"I think the degree to which you feel heard is the degree to which you see the recommendations (of the jury) acted on," she adds. "Any recommendation is just words on paper until someone does something with it. The really important part of that is that we need to monitor recommendations and what happened. Is there something that has come out of this that has improved the system?"

There is always a fear that the jury's recommendations may end up on a shelf, collecting dust. That was the hardest thing about the inquest process for Jackson. During the Katelynn Sampson inquest, the 103 recommendations made in 2014 by the jury examining the death of Jeffrey Baldwin were presented as evidence. Baldwin was another child who slipped through the cracks and died at the hands of his caregivers. "We know several recommendations just sat there," Jackson laments. "We haven't seen any changes."

"I hope people pay attention," she adds for the sake of another Jeffrey or Katelynn. "I hope these agencies actually step up to the plate. They've made some changes, but a lot of the (recommendations touch on) things they still need to do."

The hardest part to accept is that they might not do anything, Jackson says, acknowledging the jury's recommendations are not binding. **RN**

KIMBERLEY KEARSEY IS MANAGING EDITOR/COMMUNICATIONS PROJECT MANAGER FOR RNAO.

Coverage through RNAO's Legal Assistance Program (LAP) is available to all members. It is important to note it is not an automatic benefit of membership. You can sign up at any time. Find out more at RNAO.ca/LAP

DIRECTOR OF NURSING AND HEALTH POLICY

The Registered Nurses' Association of Ontario is the professional association representing registered nurses, nurse practitioners and nursing students wherever they practise in Ontario. Since 1925 RNAO has advocated for healthy public policy, promoted excellence in nursing practice, increased nurses' contribution to shaping the health system and influenced decisions that affect nurses and the public they serve.

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2017 AGM

CALL FOR RESOLUTIONS

DEADLINE: Dec. 27, 2016 at 5 p.m. EST
RNAO encourages individual members, chapters, regions without chapters and interest groups to submit a resolution for review and decision at the 2017 AGM.

CALL FOR NOMINATIONS

2017-2019 RNAO Board of Directors
DEADLINE: Dec. 27, 2016 at 5 p.m. EST
As your professional association, RNAO is committed to speaking out for nursing, speaking out for health. Your talent, expertise and activism are vital to our success. For the term 2017-2019, RNAO is seeking nominees for:

- President-elect
- Regional Representative for each of the 12 regions

Also:

- Member, Provincial Nominations Committee (two general member vacancies)
- Member, Provincial Resolutions Committee (three general member vacancies)
- Bylaws Committee (one general member vacancy)

In accordance with RNAO policies, members of board committees shall be appointed by the board of directors.

If you require further information about the AGM, the call for resolutions, or the call for nominations, including additional vacancies on any RNAO board committee not noted above, contact Sarah Pendlebury, RNAO board affairs coordinator, at spendlebury@RNAO.ca

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 BY ESTRELLA MERCURIO

ILLUSTRATION: KELLY SCHYKULSKI, COLAGENE.COM

What nursing means to me…

As an enterostomal therapist in the community, I get a tug at my heart when I see patients with ostomy who suffer from skin complications because their appliances need to be replaced, but they don't have the money to replace them. I remember one patient who was using duct tape to keep his appliance attached to his skin, hoping he could get just a little more use out of it before getting a new one. When I advise patients to replace appliances as soon as possible, their usual response is: "It's a choice between buying more appliances and buying food."

During first-time visits, I always ask ostomy patients: "Are you receiving funding?" During one such visit three years ago, my patient – like so many others – did not know there was funding for appliances available through the Ministry of Health's Assistive Device Program (ADP). "How much does the government give?" she asked.

When I told her the annual funding is $600, she was surprised. A regular ostomy patient – without skin complications – requires one-to-two appliance changes each week, costing an average of $1,300 annually. Although this patient's supplies were covered by her insurance company, she wondered how other patients without coverage were managing on only half of what they need.

I told her one of my colleagues drafted a letter to ADP, appealing for an increase a couple of years earlier, but the letter fell on deaf ears. She suggested I send an email to Ontario Premier Kathleen Wynne, whom she knew personally, and she would make sure it got to the right desk. I had an adrenaline rush. I was excited to find this connection to the premier, and to advocate for my patients. But then I wondered: what will the bureaucrats say? They may look at the letter and say: "Who is this Estrella Mercurio?"

I decided to enlist the help of my colleagues, who suggested involving the Canadian Association of Enterostomal Therapists (CAET) and Ostomy Canada, who joined our fight by sending a petition to ADP in support of our letter. Premier Wynne forwarded the letter to then Health Minister Deb Matthews. We did not see results overnight, but I'm thrilled that our request was approved.

I remember clearly how the tears welled up in my eyes when I received the call in September 2015 from the president of CAET. "I want you to be the first to know, I just got a letter from the ministry," she said to me. A 30 per cent increase effective immediately, and another 30 per cent in 2016. My tears were for my many ostomy patients who were struggling to stretch their $600. They now receive almost $1,000 annually, the first increase since the program launched in the early 1970s.

When I share this story, and patients give me a hug, and tell me how much it means to them, it just makes my heart swell that I was able to assist them in my own small way. **RN**

Estrella Mercurio is care and service manager, ET consultant, for Paramed Home Health Care in Toronto.

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