Christie Okonkwo is the first recipient of Eric Staples’ generosity. “As a new immigrant, the Staples Family Graduate Student Award in Nursing will go a long way in helping me achieve my dream of becoming an advanced practice nurse,” she says.

Furthering nursing practice through education and research is a passion Eric shared with his mother, Frances (Winfield) Staples. Both graduated from U of T’s Faculty of Nursing, but 40 years apart.

By endowing this graduate scholarship and making a bequest in his will, Eric is helping future generations of Bloomberg Nursing students achieve their education and leadership goals.

Make a bequest or endow a student scholarship, and join Eric in creating a lasting legacy. For information on giving possibilities, please contact michelle.osborne@utoronto.ca or 416.978.3846.
Contents

FEATURES

You Can Lead a Horse to Water ... 4
Encouraging practitioners to change their practice in light of new knowledge is the biggest challenge of all  
by Dean Sioban Nelson

Research That’s Changing Lives 7
Bloomberg Nursing researchers are improving practice and policy, well, just about everywhere

The Search for Truth 11
Our faculty are lead contributors to the Cochrane Collaboration, a gargantuan database designed to inform evidence-based practice

The Translator 14
Professor Cindy-Lee Dennis’s research almost immediately translated into practice

An Ounce of Prevention 16
A global health leader, Professor LaRon E. Nelson is heading a study in Ghana aimed at preventing HIV transmission between men who have sex with men

DEPARTMENTS

Letters 2
Dean’s Message 3
Q&A 19
A conversation with Ellen Hodnett, Canada’s first nursing chair, who shares her findings on what women need during childbirth

Opinion 20
In “Why Do We Still Let Babies Suffer?” Professor Bonnie Stevens probes the difficulty of translating research into practice

News 22
Spotlight on Learning 26
Here comes Maureen’s Dream Team. In the Sim Lab, Maureen Barry directs a stellar cast of instructors

Time Travel 28
Events 29
IT’S MATHER, NOT MATHEWS

I was startled, excited and gratified to see a familiar photograph in the Time Travel section of the Spring issue of Pulse. I am certain that the photograph is not of Lenore Mathews, but rather of Lenore Mather who was in the class of 1948, as I was.

Lennie and I were roommates during our years at U of T and are still in touch. After graduation, Lennie joined the Victorian Order of Nurses, working first in Toronto and then, after marrying, in Calgary, where she rose to administrative positions.

Pulse is an excellent publication with up-to-date information on the changes and progress in nursing education, as well as on the graduates. In the previous issue, I greatly appreciated the historical articles on Kathleen Russell and other pioneers. Miss Russell, as we called her more than 60 years ago, was a very visible and active part of our nursing degree program which, I believe, was still at the experimental level.

Catherine (Kay Johnston) Mowbray, BScN 4T8

Editor’s note
Lenore Mather, please accept our apologies. And congratulations on a successful nursing career!

IT WAS A SETUP!

Imagine my delight at seeing the picture of Lenore Mather (not Mathews). The picture has had a masterful tint job, but I have an enlargement in black and white as my sister, Alice Chrysler, was a photographer for the student yearbook, Torontonensis.

The photo was taken on a Sunday morning; there were no surgeries, so cleaning was our job. The smile on Lennie’s face (behind the unnecessary mask) was because it was a setup. I doubt there was any water in the pail!

Reading about the broad spectrum of nursing concerns in Pulse has impressed me with the fact that we did very little of what nurses do now. But the basics – such as the patient is a person – as taught in our first weeks by Miss (Jean) Wilson have never changed.

My scrapbooks contain a number of pictures of nursing school groups and activities. If Pulse or the Faculty of Nursing would like them, I would be glad to send them, labelled as best I can.

Barbara (Chrysler) Rooke, BScN 4T9
Fonthill, Ontario
Why is this research important? What difference will it make? What problem will it solve? Every researcher is and should be asking these questions.

These same questions are guaranteed to strike terror in the heart of every doctoral student. Even more terrifying to PhD candidates is the questions’ blunter version: So what?

Nursing is a professional discipline and, as such, our colleagues in practice and policy have every right to demand that nursing researchers and scholars apply their considerable academic training to the pressing problems of our time. But there’s more to solving problems than finding solutions. Communicating new knowledge through a wide range of dissemination strategies is every bit as important as finding new answers. Perhaps the greatest challenge, though, is supporting practitioners in using new research to enhance their practice.

At Bloomberg Nursing, our faculty, students and alumni have no time for ivory towers. In this issue of Pulse, we highlight some of our scientists who have been enormously effective in not only producing knowledge, but synthesizing and updating the state of science. From providing data to inform policy-makers at provincial and national levels, to developing research-based decision frameworks for patients and their families, to conducting systematic reviews to underpin clinical guidelines and protocols, Bloomberg Nursing researchers have made remarkable contributions to practice.

For their part, practitioners and decision-makers face a bewildering amount of information on every topic, big or small. A critical role for academics is to assist frontline practitioners in distinguishing “the signal from the noise” in research. Here too, Bloomberg Nursing faculty, students and alumni have made impressive headway, guiding practice and system change, ensuring research goals remain patient- and community-directed, and insisting outcomes are tangible and measurable.

Whether our researchers are working with practitioners in improving their understanding of pain or piloting innovative programs to prevent HIV transmission in Africa, they’re producing knowledge that makes a difference to patient care, system effectiveness and ensuring the sustainability of our health care system. By partnering with clinicians, working with colleagues from other disciplines, serving on interprofessional teams, and collaborating with policy-makers and service providers, Bloomberg Nursing researchers focus on areas of critical importance to the health of all Canadians and find answers to problems we all care about.

Bloomberg Nursing doctoral students realize the “So what?” question is the most important question of all. Over time, they learn how to explain to researchers across the health sciences the finer points of their methodology and analysis, to speak with interprofessional colleagues and nursing teams about their study and its relevance to their practice, and to communicate their findings to the general public.

For nursing researchers, embracing “So what?” is what it’s all about!
For the frontline nurse, physician, physiotherapist or social worker, the question of what works best is age-old. The problem has never been finding answers — but knowing how to judge the evidence on which the answers are based.

Around the world, researchers are conducting countless studies that shed new light on disease etiology, test new treatments and evaluate patient outcomes. Multiple epidemiological studies track population data, enabling us to develop comparators across countries, track longitudinal outcomes for particular populations, and look at health risks, screening and prevention strategies.

A simple Google search quickly demonstrates the extraordinary range of seemingly authoritative studies providing contradictory findings to confound patients, clinicians and policy-makers alike. From decrees such as “All fats are bad” to “Some fats are good,” and “Bed rest is best” to “Mobilization for all,” there is a never-ending river of data that flows into scientific journals and onto the web. James Gleick describes this deluge in his recent book, The Information: A history, a theory, a flood. He argues that over the last 50 years we have been transformed into information consumers, absorbing this data flow like sponges, with an ever-decreasing capacity to process it.

For the contemporary practitioner, the exponential increase in information presents a major functional challenge. Seventy years ago, when Scottish physician Dr. Archie Cochrane treated his fellow prison-camp inmates for tuberculosis, he practised what he knew to be the latest approach: bed rest, pneumothorax and pneumoperitoneum. As Cochrane later lamented, he had no idea if his treatments were curing or killing his patients. Sadly, he suspected the latter.

In 1972, Cochrane’s book Effectiveness and Efficiency: Random reflections on health services came out. Partly as a consequence of this influential bestseller and his life work promoting the creation of standards for judging evidence, the evidence-based medicine movement emerged in the 1980s. It sought to synthesize the state of knowledge on a particular condition or topic to provide practitioners with a resource to support their clinical decision-making, and guide service providers and policy-makers in how to organize health care to use resources efficiently and achieve optimal patient outcomes.

MAKING SENSE OF IT ALL

The Cochrane Collaboration’s database of systematic reviews engage more than 15,000 researchers in preparing and maintaining reviews of scientific evidence. While Cochrane is the world’s most extensive system for offering advice to clinicians on the basis of current “evidence,” it is certainly not the only such initiative. Others include the Joanna Briggs Institute, an Australian-based collaboration on research evidence, largely targeting nursing; and the U.S. Department of Human Services National Registry of Evidence-based Programs and Practices (NREPP). Across Ontario and Canada, service providers have widely taken up RNAO’s Best Practice Guidelines. And increasingly, they’re being used internationally.

Producing relevant science is, of course, only the first step. Ensuring the information is accessible and available in a distilled format for end-users is the second. But finding the water and taking it to the horse achieves little unless the horse decides to drink it!

Encouraging practitioners to revise their thinking and change their practices in light of new information is the biggest challenge of all. In fact, the question of implementation has been the subject of an emerging field of science, with empirically validated methods to encourage and enable clinicians and organizations to be active research users and strong partners in knowledge development.

OUR AGRARIAN ROOTS

It may surprise those of us who understand the importance of connecting our publicly funded research enterprises with our publicly funded health care system, that much of the theoretical heavy lifting in the field of innovation and knowledge transfer took place with the development of “agricultural extension.” Early modern examples of government-funded programs to use science to improve social...
policy go back to the mid-19th century potato famine in Ireland and the programs the British government introduced to teach Irish farmers how to grow different crops. Getting farmers to adopt more efficient techniques to improve yields was a way to build the country’s capacity to feed its citizens and generate wealth through exports. Extension, as a state-led intervention that brought science into practice, gained momentum throughout the 20th century – from the dust bowl farms of the Midwest during the Depression, to the rice fields of India and China after the Second World War.

Agriculture extension provided important lessons to the knowledge transfer field. By going into the field (literally), extension officers, or knowledge workers as we would call them today, learned that effective communication is two-way. Traditional practices – such as seed preference, animal husbandry, water usage and harvesting – depend on a variety of considerations, including the farmers’ intimate knowledge of their land and climate, social practices in which labour and other resources are shared, and customs and cultural preferences. All of these components are critical to the success of any new program.

Everett Rogers, an American rural sociologist, understood these confounding issues and published his seminal text on diffusion of innovations theory in 1962. The theory is based on a meta-analysis of studies, and it sets out a model that encompassed the social and contextual complexity of change. Rogers’ theory became one of the most cited works in the social sciences and led to the opening of an entire field of implementation science that works to bridge the gap between research and practice.

ALTOGETHER NOW

Bridging the gap and focusing on improved outcomes entailed a major shift in thinking by funders and policymakers alike, and the health care field enthusiastically adopted this research approach. The Canadian Institutes of Health Research has declared knowledge translation a fundamental, essential element of publicly funded research. It defines knowledge translation as a “process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system.”

The “evidence-based” movement in health care is a response to a key contemporary challenge for health care: being data rich and information poor. Evidence-based research and practice, however, are not without their critics. Some see the heavy weighting of randomized controlled trials as the benchmark for strong evidence as an attack on qualitative research and the triumph of a simplistic form of positivism. Notwithstanding this critique of the new empiricism that guides practice guidelines and protocols and its cautionary note on the limits of generalizability in evidence-based science, the vast amount of information that assails the average clinician or policy-maker desperately requires an organizational frame – if only for sanity’s sake!

The state of the science, however, is only half the story. For a practitioner to change his or her practice and adopt new ideas, implementation theory emphasizes the importance of context and the social dimensions of practice change. It calls on researchers to engage with frontline practitioners and listen to the field. This is the heart of a research-based practice and research-based profession: interconnected researchers and practitioners responding to questions that emerge from practice, and working with each other to develop new approaches that can be successfully applied in practice.

In a sense, this combination of evidence and context is the core of nursing practice: sound, research-based practice combined with a deep understanding of the everyday reality of patients’ lives. Protocols and guidelines alone do not lead to excellent care or better outcomes, nor does tacit knowledge arise independently of science. It is the combination of the two paths – Archie Cochrane and the synthesis of knowledge to date, and Everett Rogers and the world of implementation science – that allows the frontline knowledge worker (known to us as the nurse) to both make sense of it all and put it into practice to improve health for all. It’s the bridge to better health outcomes upon which we all rely.

Canadian Institutes of Health Research: www.cihr-irsc.gc.ca/e/29418.html.


With all the concern about the health care system, the worry about research funding and the practice of poking holes in knowledge exchange theories, it’s easy to lose sight of what knowledge translation is all about.

It’s not about writing reports to gather dust in the library. It’s not about exploring ideas just because they’re interesting. Knowledge translation is about gleaning insights from the research so these revelations can help others – whether it’s by making a debilitating disease a little less painful or enabling a patient to make an informed medical decision.

Getting research discoveries into practice is difficult, but no one at Bloomberg Nursing is about to give up. Visit the Faculty on any given day, and it’s a beehive of activity. And the focus is always external, on how to help others.

One way Bloomberg Nursing professors help others is by researching how to strengthen our health care system. Professor Linda McGillis Hall, MScN 9T3, PhD 9T9, in particular, is advocating for “policies and initiatives that have some teeth.” She studies why Canadian nurses go to the U.S. to practise, and her research shows the number 1 reason why nurses emigrate is to find the full-time work our health care system isn’t offering.

McGillis Hall is helping inform the decisions of policymakers, elected officials and health care executives. You can find the research findings of McGillis Hall and other Bloomberg Nursing professors and alumni on almost every page of the Canadian Federation of Nurses Unions’ report Experts and Evidence: Opportunities for Nurses. Published last year, this lobbying tool highlights solutions for eliminating the nursing shortage. A synthesis of research findings, it urges health ministers to make evidence-based choices that will not only make the health care system sustainable, but improve health outcomes.

In the preface, Judith Shamian, president of the Canadian Nurses Association and a Bloomberg Nursing professor (status), points out the false economy of reducing the number of nurses. She writes, “Cuts to nursing are cuts to quality of care, and they actually increase costs to the system.”

Gail Tomblin Murphy, PhD 0T5, backs up Shamian’s statement by providing the data. The Bloomberg professor (status) has calculated that Canada will be short 20,000 nurses by 2012, and up to 60,000 by 2022.

Flip the page and there’s Ann Tourangeau’s research on what makes nurses think about leaving their jobs. This Bloomberg Nursing prof hopes to curtail nursing shortages by reducing turnover.

EASING THE PAIN
For her doctoral dissertation, Janet Yamada, BScN 8T6, PhD 1T1, evaluated ways to translate an improved pain-management intervention into practice in the neonatal ICU.
The intervention was simple: place a few drops of a sucrose solution on the baby’s tongue prior to a painful procedure, such as a needle or heel prick. If the intervention is lengthy, give the baby another drop midway through.

“Sucrose calms babies down right away,” says Yamada, who is also a nursing research associate at The Hospital for Sick Children. “It has been found that giving sucrose to babies decreases the indicators of pain, such as crying, after a painful event.”

To introduce the intervention, Yamada asked interested members of the health care team to develop strategies to implement the change, and then supported these “key champions” in their efforts.

The champions had no shortage of ideas. They came up with a way to remind health professionals to administer sucrose: a bright, cheery sticker saying “How sweet it is” that could be put on the charts. Then they reinforced the message by designing a poster that read “Be sweet to babies.”

“You need buy-in, supportive leadership and a change in the belief system of the care providers to really affect policy about pain management,” says Yamada. “It worked because the change meant something to the health care team, who want to do what’s best for the baby.”

Jennifer Stinson, MSc ’06, PhD ’06, a Bloomberg assistant professor (status), researches e-health technologies to better assess and manage pain in children with chronic and life-threatening illnesses. For example, she developed and tested a smartphone pain diary for kids aged eight to 18 with chronic arthritis. “The patients loved it, and the parents loved that we were asking about their child’s pain,” says Stinson, who is also an NP in the Chronic Pain Program at the Hospital for Sick Children.

To translate the research into practice, though, it wasn’t enough for the pain diary to be a hit with families. The health care team had to embrace it. “Practitioners wanted to be sure the electronic pain diary wouldn’t increase their workload,” says Stinson, “and they wanted data. They wanted to see that the technology would actually decrease the number of visits to the hospital or calls to the health care team. They wanted to see it improved management of the child’s pain.”

It was soon obvious the electronic pain diary improves communication and decision-making about pain management. By printing the pain diary, a member of the health care team can read a day-by-day account of the child’s pain and what helped or made it worse. Before Stinson introduced the e-diary, the doctor or nurse would ask, ‘Do you have any pain?’ and the child might shrug his shoulders, says Stinson. “Or, the child might respond ‘No, I don’t have any pain’ because he didn’t want to change his meds.”

Now Stinson is working on a way to regularly communicate the pain information a child electronically records every day to his or her health care team. With this system, a member of the team – likely an NP – will be able to respond with suggestions on how to better control the pain. If the child is managing his or her pain well, the NP can simply text, “Keep up the good work!”

**INFLUENCING THE CARE OF THE ELDERLY**

“I believe knowledge translation is one-to-one,” says Professor Kathy McGilton, BSc ’07, MScN ’03, PhD ’07. “How does knowledge transfer? Through relationships.”

In her most recent study, McGilton examined the rehabilitation care of elderly patients with dementia who had been living in the community before undergoing hip fracture surgery. She soon learned that not only was there no standardized care for these patients, but rehabilitation services were seldom an option. “Because they had cognitive impair-
ment, they were excluded from the rehabilitation programs everyone else takes for granted,” says McGilton, who is also a senior scientist at Toronto Rehab.

Without rehabilitation following hip surgery, these clients suffered limited mobility and a further decline in their cognitive abilities. Often, they required an extended stay in acute care and then were transferred to a long-term care facility. “They wanted to go home and deserved that opportunity, just like everyone else,” McGilton says.

She developed a patient-centred rehabilitation model in which an advanced practice nurse (APN) with expertise in gerontology served as the facilitator or “knowledge broker” for the unit. The master’s prepared nurse would transfer knowledge primarily through role modelling with individual nurses. Practising alongside the unit nurses, the APN would make a connection with each nurse and patient, and mentor the nurses on how to assess and care for patients with cognitive impairment to keep the patients as independent as possible. And it was by developing a one-to-one mentoring relationship with the unit nurses that knowledge was transferred.

McGilton and team pilot tested the model at Toronto Rehab with patients with cognitive impairment who had been living in the community. They found these patients achieved the same functional status and had the same length of stay as those without dementia and were able to go back home.

Since then, the model has been implemented in multiple facilities in Ontario and is about to go national. “We can make such a difference with this population,” says McGilton.

**CHALLENGING INEQUITIES**

“Nobody knew where the biggest gaps were in women’s health,” says Dr. Arlene Bierman, the principal investigator of the Project for an Ontario Women’s Health Evidence-Based Report (POWER). “The health inequities among women as-sociated with gender, income, education and ethnicity are much bigger than I thought they would be in Canada.”

For example, the study found women with a low income were much more likely to report poor health, disabilities and multiple chronic conditions than women with higher incomes. One-third of women with a low income living in the community report their activities are limited by pain; and one in four of these women report food insecurity or difficulty buying food. “The good news is we do a fairly good job of providing equitable care when people are very sick,” says Bierman.

While universal access to health care services is a fundamental principle of the Canadian health care system, Bierman points to the importance of the social determinants of health. “A lot of things that shape health are beyond the health care system,” she says. “Achieving health equity is key to the sustainability of our health care system.”

Along with the more than 60 researchers who collaborat-ed on POWER, Professor Bierman created an evidence-based tool for health care providers, policy-makers and consumers. POWER emphasizes indicators that are modifiable and can support intervention efforts. “Knowledge translation has been an important focus of our community-engaged research approach,” she says. For the LHINs, POWER has hosted webinars in which each LHIN receives their own detailed data so they can benchmark their performance.

“We’ve been amazed at the pickup of our work,” says Bierman, glancing at her laptop to note that the website has had more than 30,000 downloads of the reports and visitors from 132 countries. “Our model of including gender and equity analysis with performance measurement, and reporting and bridging population health and clinical prac-tice has generated global interest.”
HELPING CLIENTS MAKE INFORMED DECISIONS

In partnership with a health care provider, decision support tools can help patients sort through their options and make an evidence-based choice. “A decision support tool is a knowledge translation device,” says Professor Mike McGillion, PhD OT6, who received funding from the Canadian Institutes of Health Research to develop a tool to help people with refractory angina (RFA) make treatment decisions.

RFA is severe cardiac pain that persists despite medical therapy and invasive coronary interventions. When a patient’s cardiac pain increases, it always begs the terrifying question: Am I having another heart attack?

“Unrelieved cardiac pain is a serious clinical issue,” says McGillion, explaining that it can cascade into a multitude of negative consequences. For example, it can lead to a sedentary lifestyle, which introduces its own set of health problems.

McGillion calls for an integrated, co-ordinated effort of the cardiovascular and pain science communities to help this growing and debilitated population. “There’s a big gap between the cardiovascular and pain sciences,” says McGillion, who serves on the Canadian Pain Society (CPS) board. “Expert knowledge of persistent cardiac pain is limited. While there is some collaboration, many patients with RFA make frequent visits to the emergency department and undergo repeated cardiac investigations in lieu of appropriate care.”

One way McGillion is addressing this gap is by taking on the role of a co-guest editor of an upcoming Canadian Journal of Cardiology supplement on persistent cardiac pain.

After leading the development of the joint Canadian Cardiovascular Society-CPS clinical practice guidelines on RFA management, McGillion’s current project will move the guidelines into practice through the decision support tool. In previous research, he contributed to the findings that people with RFA lack adequate information about viable treatment options and are at risk for inappropriate treatment.

“Services are inconsistent across Canada,” he explains. In one province, you might be presented with a number of RFA treatment options; in another province, options can be quite limited. The decision support tool will help clinicians and patients look at the strength of the evidence for each of the myriad potential treatment options. Some of the options are invasive, and others aren’t covered by provincial health insurance plans.

In October, McGillion will be leading his team of 21 co-investigators, clinician stakeholders and patient representatives in a consensus conference to develop the tool. In partnership with the Canadian Pain Coalition, they’ll examine the acceptability and utility of the tool at eight cardiac centres across Canada.

“Decision-making about RFA treatment is a complex process,” says McGillion, “There are many factors to consider, such as risks versus benefits, and cost and feasibility of treatment options. The effective knowledge translation of this information is critical to making informed and effective treatment decisions.”

Two offices away, Professor Kelly Metcalfe is developing a decision support tool for women with a genetic predisposition to breast cancer. Some of these women face the difficult decision of whether to opt for a prophylactic mastectomy and/or oophorectomy to prevent cancer.

Metcalfe is heading a randomized control study involving 150 women, each of whom have the BRCA1 and BRCA2 mutation responsible for the increased risk. Half of the women will receive standard care, and half will be given Metcalfe’s eight-page decision aid. “We need to know the decision aid is not causing harm,” she says.

The aid provides information on all possible treatments – including medications and increased MRI screening – as well as the option of doing nothing. “It helps women decide what is important to them, and then helps them make the decision of what’s right for them,” explains Metcalfe. If the tool proves useful, she envisions it being available at genetic counselling centres as well as online. “It’s important for women to know all their options,” she says.

RNAO’S BEST PRACTICE GUIDELINES

THE BEST YOU CAN BE!

The guidelines are founded on the best evidence-based information

Go to any nursing workplace or classroom in Canada and ask the nurses if they’ve heard of or used Ontario’s Best Practice Guidelines (BPGs). Chances are most hands will go up.

What began in 1999 as a distant vision has turned into a robust reality. There are now 44 BPGs, and another 10 are being developed. They’re used to inform clinical practice, administration, education and policy both at home and abroad. Many BPGs have been translated into Spanish, Italian, Mandarin and Japanese.

The guidelines have been adapted for PDAs, BlackBerries, iPhones and Android devices so this important nursing knowledge can be at a nurse’s fingertips. On iTunes, the BPG application consistently rates in the top-three downloaded medical apps.

Alongside this amazing journey, a fertile evaluative research program has developed. The Nursing Best Practice Research Unit, launched by RNAO and the University of Ottawa in 2006, draws together service, academia and professional association partners to bring the best knowledge to nursing and health care in order to improve people’s health and system outcomes.

The success of the BPG program is largely due to the active engagement of the nursing community – the enthusiasm has been contagious! At least 30,000 nurses in Canada have contributed to BPG development, dissemination and uptake, and RNAO has awarded the organizations in which many of them practise the title of Best Practice Spotlight Organization (BPSO). Interest in becoming a BPSO is tremendous; there are new BPSO service and academic sites in Spain, Italy and the U.S. Soon, there’ll be BPSO organizations in Australia, Colombia, Chile and Dubai.

Kudos to all Ontario nurses for our collective success!

– Doris Grinspun, Bloomberg Nursing adjunct professor, executive director of RNAO
Your husband wants you to switch from coffee to green tea because he’s convinced it prevents cancer. But you like your cuppa java. One way to end this angst is to go online and consult the Cochrane Collaboration.

Cochrane has synthesized the best available research on a multitude of health topics. Enter “green tea, cancer” in its search engine, and in a millisecond a review of 51 studies pops on your computer screen. The authors conclude: “There is insufficient and conflicting evidence to give any firm recommendations regarding green tea consumption for cancer prevention.”

It’s hard to argue with 51 studies. And it’s hard not to be impressed with the earnestness with which Cochrane searches for the truth. Can antibiotics help alleviate the symptoms of a sore throat? What is the efficacy of human growth hormone in adults with short bowel syndrome? Should prophylactic somatostatin analogues be routinely used in pancreatic surgery? While the definitive answers to these and other health care questions may be beyond our grasp, you’ll find the current truth – as siphoned from the best available evidence – on Cochrane.

The Cochrane Collaboration is designed to help health care providers, policy-makers and individuals make evidence-based decisions. It covers everything from interventions to prevent and treat specific illnesses, to the accuracy of diagnostic tests. Many of the contributors to Cochrane are world leaders in their field. Many are from Bloomberg Nursing.

STUDYING THE STUDIES
Cochrane draws from the highest calibre research. For the most part, the research studies are randomized control trials that have been published in a peer-reviewed journal.

“It was an honour when one of my studies was chosen for use in Cochrane,” says Professor Monica Parry, PhD 0T8, who researches supportive care measures for individuals with acute and chronic cardiovascular disease. “It’s adding to the knowledge, and you know it’s being used around the world.”

As the lead author, Professor Cindy-Lee Dennis, BScN 9T1, PhD 9T9, has conducted eight Cochrane reviews primarily on depression in the perinatal period (from pregnancy to first year postpartum). Recently, Dennis, with assistance from Julie Weston, BScN 7T6, completed a Cochrane review on psychosocial and psychological interventions for preventing postpartum depression. A comprehensive search identified more than 85 new investigations on the topic. They reviewed each study for inclusion/exclusion criteria and methodological quality. In the end, they decided only 26 randomized controlled trials made the grade for inclusion in the systematic review and meta-analyses.

THE COCHRANE COLLABORATION
IS DESIGNED TO HELP HEALTH CARE PROVIDERS, POLICY-MAKERS AND INDIVIDUALS MAKE EVIDENCE-BASED DECISIONS

The Collaboration is named after Archie Cochrane, a British epidemiologist.
SEEKING THE TRUTH
Cochrane is much more than a collection of elite research studies. As part of the systematic review process, experts analyze the studies using a standardized methodology to see if the researchers have arrived at the same conclusions. Through this process, the kernel of truth is extracted.

Janet Yamada, BScN 8T6, PhD 8T1, who researches how to manage pain in infants and children, has worked on several Cochrane systematic reviews. She notes that some reviews hit a chord. For example, Sucrose for analgesia in newborn infants undergoing painful procedures, which she contributed to, is “highly accessed by both clinicians and researchers,” she says.

Yamada has shared her knowledge on systematic reviews with Bloomberg Nursing students, both informally and as a guest lecturer in the Theories of Pain course. Yamada has even worked on a review of systematic reviews, which was published in Pain Research & Management.

At least 4,500 researchers and clinicians participate in the systematic review process, but it isn’t enough. Cochrane estimates it needs at least 10,000 more reviews to cover all of the available health care interventions.

THANKS ARCHIE
The Cochrane Collaboration, established in 1993, is named after Archie Cochrane, a British epidemiologist who advocated for informing health care practice through randomized controlled trials.

Professor Ellen Hodnett, MScN 8T0, PhD 8T3, contributed to the Oxford Database of Perinatal Trials, a forerunner of the Cochrane Collaboration. “The external appraiser on my PhD thesis back in 1983 was one of the initiators of systematic reviews of forms of care during pregnancy and childbirth. And he really sparked my interest in getting involved,” says Hodnett. “One of my reviews of continuous labour support gained a huge amount of attention worldwide. It led to new national practice guidelines in Canada, the U.S. and U.K.” Hodnett became an editor of the Cochrane Pregnancy and Childbirth Group, fulfilling the role for almost 20 years.

In January of this year, Cochrane took a huge step forward. The World Health Organization awarded it a seat in its World Health Assembly, a position that allows the collaborative to provide input on WHO health resolutions and link high-quality evidence to practice recommendations. WHO also established a formal partnership with Cochrane by inviting it to its executive board meeting. It’s almost as if Cochrane has become a country onto itself.
Professor Ellen Hodnett’s reviews of continuous labour support during childbirth attracted international attention.

VISIT THE LIBRARY
Cochrane reviews are published in the Cochrane Library, an online collection of databases. Visit to check the effectiveness of a diagnostic test or health care intervention. It’s easy to use. If you know how to use a search engine, you know how to use the Cochrane Library.

You can access the abstracts for free. Each abstract includes the main results, the authors’ conclusions and a plain language summary. If you want the full article, you need to subscribe, and Canadians are currently being offered a six-month free trial. Or, check with your practice setting to see if it has a subscription; it probably does.

Of course, there is a multitude of ways to access information in the Cochrane Library. For example, you can search by author’s name. Or, you can look into the special collections, which are anthologies of reviews on topics such as telemedicine, metastatic breast cancer and burns.

While you’re visiting the library, join its Cochrane Journal Club. You’ll receive a free, monthly publication that introduces a recent Cochrane review. The publication includes a podcast explaining the key points of the review and downloadable PowerPoint slides containing key figures and tables. Take that to your next journal club meeting!
Cindy-Lee Dennis’s postpartum depression (PPD) research has been a critical resource to the development of the Ontario Ministry’s Healthy Babies Healthy Children program, which assesses virtually every new mother in the province for the disorder. But the influence of her research extends far beyond our provincial borders.

Helplines in several provinces, including Quebec and New Brunswick, are based on Dennis’s model of mothers helping mothers. And the Breastfeeding Self-Efficacy Scale she developed is nothing less than an international sensation. Researchers and clinicians in more than 30 countries are using her scale to identify mothers at high risk of discontinuing breastfeeding.

Dennis, BScN 9T1, PhD 9T9, focuses her research on improving maternal health. Her mantra: healthy babies start with healthy moms. The Bloomberg Nursing associate professor’s investigations are supported, in part, by two research chairs. Dennis holds a U of T Canada Research Chair in Perinatal Community Health. And recently, she became the Shirley Brown Chair in Women’s Mental Health Research at the Women’s College Research Institute.

**Breastfeeding Matters**

Dennis’s interest in the perinatal stage started with the first essay she wrote in U of T’s undergraduate nursing program. “I was immediately interested in breastfeeding and why women discontinued before the recommended time period,” she says.

For her doctoral dissertation, Dennis conducted a randomized controlled trial to evaluate how peer (mother-to-mother) support affects breastfeeding duration. She recruited more than 250 new breastfeeding mothers and provided those allocated to the intervention group with telephone-based support from another mother in the community who successfully breastfed to six months postpartum and participated in a two-hour training session. She found that mothers who received the phone peer support were almost three times more likely to continue breastfeeding to 12 weeks postpartum and do so exclusively.

**Telephone-Based Support**

Today, Dennis is researching innovative ways to prevent and treat PPD. One of her investigations found telephone-based support from a peer can cut the incidence of PPD in high-risk women by 50 per cent. In this prevention trial, Dennis and her team arranged for a mother who had experienced PPD to phone a new mother with beginning depressive symptoms within the first two weeks postpartum. “Peers can normalize difficulties while also providing encouragement, positive feedback and a sense of belonging,” says Dennis. “They can also help new mothers overcome loneliness and isolation.”

“Treatment barriers are another important issue related to postpartum depression in new mothers,” she continues. Since the mother may have other children at home, lack transportation or not have access to a specialized health professional, the phone is often the most viable treatment mode. Accordingly, Dennis is completing another study to evaluate telephone-based interpersonal psychotherapy in treating PPD among women in rural and remote areas.

YOUR HELP NEEDED

All health care professionals who come in contact with new mothers should assess them for depressive symptoms, suggests Cindy-Lee Dennis. Then if appropriate, they should refer them to specialized services in a nonjudgmental manner. “We need to make it safe for these women to receive assistance,” she says.

Dennis has identified several barriers that prevent new mothers from seeking help for depression, including:

- fear of stigmatization,
- being unable to identify they’re depressed, and
- not knowing where to turn for help.

In this trial, highly trained and supervised nurses are providing interpersonal psychotherapy to depressed mothers everywhere from northern British Columbia to Peggy’s Cove, Nova Scotia.

**Including the Father**

Dennis is also helping move paternal PPD out of the shadows. Her “Impact of Maternal and Paternal Postpartum Depression Study” will probe the effect of single and dual parental depression on infant development. The multisite study, now under development, has a goal of following more than 4,000 parents for two years.

And she’s recruiting for a study to examine the health of immigrant mothers and infants. “Immigrant mothers are five times more likely to develop postpartum depression than Canadian-born mothers,” Dennis says. “It is very important to look into why this vulnerable maternal group is at higher risk of developing PPD so effective identification and treatment interventions can be implemented.”

**The Translator**

This professor’s research almost immediately translated into practice.
LaRon E. Nelson

An Ounce of Prevention...

A global health leader, this Bloomberg professor is heading a study in Ghana aimed at preventing HIV transmission between men who have sex with men.
Professor LaRon E. Nelson is dedicating his research career to preventing HIV and other sexually transmitted diseases (STDs) among socially marginalized groups in African and African diaspora communities. Nelson feels this focus is essential not only because these groups are most at risk of STDs, but because they often experience significant barriers to accessing health care.

For the past two years, Nelson and his team have been developing an HIV prevention strategy in Ghana for men who have sex with men (MSM). In a country where about 25 per cent of MSM have HIV, these men are afraid to ask for help in preventing HIV infection. “Because of HIV stigma and the discrimination against men who have sex with men, many do not feel safe seeking out HIV prevention services,” explains Nelson.

To address these issues, the team consulted with public health officials and men in the target group in Ghana’s two largest cities, Kumasi and Accra. “From both an ethical and scientific standpoint, you can’t develop an intervention for a community without first understanding who they are, how they live and what they value,” says the Bloomberg Nursing assistant professor. “We had to make it culturally relevant; otherwise it would just be a waste of time.”

EVERYONE HAS SOMETHING TO OFFER

Nelson’s interprofessional research team includes professors from Kwame Nkrumah University of Science and Technology in Kumasi, and several American universities, including Emory and Brown. The team has members from the nursing, medicine, ethnography, community psychology, African studies and public health fields. “We knew that to deal with the complexity, we needed a team that reached beyond nursing and medicine,” says Nelson.

The team is developing a culturally grounded model to facilitate the use of condoms, reduce the number of sexual partners an individual has, and introduce a new medication that helps prevent the transmission of HIV if exposed to it. As Nelson points out, “These men are not just bodies from which to prevent HIV, they are living social beings who have a spirit and a culture. They live in communities in which they are valued for their contribution, but threatened for their sexuality.”

The model utilizes key, respected men in the community’s social and sexual networks. “Within the safety of these networks, the peer leaders will be utilized to deliver HIV risk-reduction interventions,” Nelson explains.

If the “Kumasi & Accra Project to Prevent AIDS” (KAPPA) model proves feasible, it could significantly reduce and prevent the spread of HIV among MSM in Ghana. Moreover, it could be adapted to prevent the spread of HIV in other countries and among other populations.

A DAILY PILL

The model proposes employing a recent biomedical advance for preventing HIV transmission: pre-exposure prophylaxis (PrEP). In 2010, the New England Journal of Medicine reported that taking the antiretroviral medication every day reduced new HIV infections by nearly 50 per cent among 2,499 MSM who live in low-income countries. The sub-analyses revealed that as adherence increased, PrEP’s effectiveness in reducing HIV infections also increased, reaching up to 90 per cent.

The study model will be tested in Ghana because of the urgent need there, and because Ghanaians have played a vital role in informing and planning the project. “It’s logical and respectful that the community that supported the development of the KAPPA concept have the opportunity to use it first,” says Nelson. “It’s important to the team that Ghanaian men benefit from the research.”

After the study’s conclusion, Nelson will continue to work closely with leaders in Ghana to implement the medical and public health policies necessary to evaluate KAPPA’s effectiveness for preventing HIV and the economic feasibility of the project being locally sustained.

A RISING STAR

In recognition of his commitment and determination to prevent HIV and save lives in socially marginalized communities, Grand Challenges Canada recently named LaRon E. Nelson a Canada Rising Star in Global Health. The honour came with a $100,000 grant to further his research.

Illustration: Rebecca Baran

Photo: Rebecca Baran
My name is Nancy May
I arrived on Dec 2 1935
My Mother and Daddy are

Nurses
Dorothy
Thelma
Ethel
Kathryn
Lucille
Sister Martha

Mrs. Harold B. and Mr. Harald B. were the parents of
May and Dorothy. Nancy was the daughter of Nancy
and Harald B. and was born in the former Miss
Dressel House.

Mr. and Mrs. Harald B. were the proud parents of
May and Dorothy. Nancy was the daughter of Nancy
and Harald B. and was born in the former Miss
Dressel House.
Pulse: What sparked your interest in childbirth?
Hodnett: I’ve always loved labour and delivery. One of my first jobs was as a labour and delivery nurse, and then I was the unit manager for five years.

As a novice, I had a wonderful mentor on the unit. We observed that on admission, a lot of women would tell us, “My contractions were strong and every three minutes at home, but they seem to have gone away.” My mentor would say, “Don’t worry about it. After we finish your admission routine and you settle in, your contractions will come back.” And in those days, the admission routine included a perineal shave and an enema; it was quite unpleasant.

For most women, the contractions did come back. For some women, though, the contractions didn’t return. They were the ones who developed complications and ended up needing a caesarean or other intervention. I began to wonder why. In retrospect, my entire career has been guided by these initial observations on how women are affected by the environment in which they labour.

Pulse: How do you feel the birth experience is for women now?
Hodnett: It is an unnecessarily high-tech experience. In North America, the caesarean section rate continues to rise with no demonstrable benefit for the babies and added risk to the mothers.

Continuous labour support is the only known intervention to reduce the chance of a caesarean in normal, healthy women. But our large international trial of almost 7,000 women showed that the benefits of labour support are overpowered by the effects of routine medical interventions, such as continuous electronic fetal monitoring, IV oxytocin and epidural analgesia. Studies comparing alternative birth settings to typical hospital labour wards have shown that calming, home-like settings increase the rate of a spontaneous birth. The birth environment has a powerful effect; and for most North American women, the birth environment is far from optimum.

Pulse: How important is the father’s presence during birth?
Hodnett: If the father wants to be present and his partner wants him there, of course he should attend. It’s his partner giving birth and their baby being born. But fathers are not a substitute for labour support by a professional. What training have most fathers had? A few prenatal classes? And fathers need support as well.

A story of bad knowledge translation relates to this point about fathers. The media took the results from our labour support study and distorted them. One of the newspaper headlines read “Husbands add to labour pain.” And our study wasn’t even about husbands!

I got an email from a father in Thunder Bay who had read this nonsense. He wrote, “I was with my wife for the birth of our first two children, and it was amazing. Now it looks like my presence would be harmful. Should I not be there for the third birth?” At least he contacted me, and I could set him straight.

Pulse: What did the Heather M. Reisman Chair in Perinatal Nursing Research enable you to do?
Hodnett: Holding the chair meant I had time to lead and be involved in many studies simultaneously. I set up a randomized controlled trials (RCT) unit, which I think was the first one for nurses in North America. On the RCT unit, experienced trials staff, senior and junior investigators, and students could work together.

Professor Ellen Hodnett, MScN 8T0, PhD 8T3, has just completed her third and final term as the Heather M. Reisman Chair in Perinatal Nursing Research. For almost 20 years, Hodnett served as an editor of the Pregnancy and Childbirth Group of the Cochrane Collaboration. At Bloomberg Nursing, she has been the co-ordinator of the PhD program. And at U of T, she chairs the Academic Board of Governing Council.
Having an environment that offered state-of-the-science methods and resources meant young investigators, such as Cindy-Lee Dennis and Robyn Stremler, who are now Bloomberg Nursing professors, received the technical support and mentoring they needed to launch their research careers. Now Cindy-Lee holds not one, but two chairs. I’m sure no one else in nursing has achieved that!

**Pulse: Why didn’t Canada have a nursing chair until 1996?**

**Hodnett:** There were many chairs for health care research, but perhaps research in nursing wasn’t as visible then. Dorothy Pringle, who was dean, and Judith Shamian, who was vice-president of nursing at Mount Sinai at the time, put their heads together and decided there needed to be a nursing research chair in Canada. And off they went to make it happen.

**Pulse: How have you made a difference?**

**Hodnett:** My Cochrane Review of Continuous Labour Support led to national practice guidelines in North America and the U.K. It also led to two federal laws, in Brazil and Uruguay, which give women the right to support during labour. The fact that any country needed a law to allow women to have somebody with them during labour says a lot about the status of women in some societies.

I’ve been fortunate to have had a number of firsts in my career. For example, I was the first nurse to chair the Randomized Controlled Trials Peer Review Committee of the Canadian Institutes of Health Research.

At the time, efforts were being made to broaden the research mandate to include all of health care research, not just medical research.

I was also the first nurse to be appointed to the Scientific and Technical Advisory Group of WHO’s Reproductive Health Research Program. The majority of the group’s members are from low-income countries, where nurses have little status and power.

And our RCT unit has been the training ground for the best nurse trialists in North America. I like to think I’ve helped pave the way for many nurse investigators to achieve great things in the future. It has been hugely satisfying to mentor the best PhD students, several of whom have launched important research programs in Canadian universities, including here at U of T.

**Pulse: What will it take for more of your research knowledge to translate into practice?**

**Hodnett:** Trying to persuade people through practice guidelines and educational workshops is a waste of time and energy. Practice guidelines are a necessary but insufficient condition for change.

To change behaviour, you have to pay attention to everything that influences it. When you change the environment to make it easy to provide evidence-based care, it’s much more likely to happen.

**Pulse: How would labour and delivery be different if men gave birth?**

**Hodnett:** That’s a trial I’m not willing to do! As a species, I think we’d pretty quickly become extinct.

Opinion

**WHY DO WE STILL LET BABIES SUFFER?**

**by BONNIE STEVENS**

**Until a few decades ago, health care practitioners believed babies and young children were incapable of experiencing pain, even during surgery. A number of erroneous beliefs—most notably, that a fully developed nervous system is a prerequisite for pain—resulted in newborn babies having painful procedures without any pain management.**

Interestingly, it was a mother, Jill Lawson, advocating for her infant son who underwent surgery to correct a heart defect without either anaesthesia or analgesia and ultimately died, who challenged the status quo. In 1986, in an account the Washington Post published, Lawson began arguing against the long-held beliefs that an infant can’t feel pain or tolerate powerful drugs. Her impassioned protest focused on the practice of babies undergoing painful interventions with inadequate or no pain management, and the suffering and other consequences that ensued.

Since then, research establishing the infant’s capacity for pain, and pain assessment and management strategies has grown exponentially. Nurses, in particular, played a key role in the initial development of pain measures for infants and children. However, change in clinical practice to prevent or minimize procedural pain in babies and young children, based on research results, has lagged behind and is of continuing concern. Finding ways to implement research findings—to bridge the gap between research and clinical practice—has been a major challenge for researchers, clinicians, administrators and educators.

Research is fundamental to generating new evidence on safe, effective pain management strategies. It’s also necessary to determine the most effective ways to implement evidence into clinical practice. Effective implementation strategies encompass the translation of research findings into a usable form, such as guidelines, policies and procedures. Despite significant advances in the field of knowledge translation (also called research utilization, knowledge transfer/exchange and
Researchers know how to prevent or minimize pain in babies undergoing painful procedures. Now the challenge is translating these findings into practice
Spring Reunion 2011

In May, about 150 alumni headed back to school for Spring Reunion. Following a buffet breakfast and the Distinguished Alumni Awards presentation, the graduates toured our state-of-the-art Simulation Lab (SIM Lab) where they met and interacted with the computerized mannequins that students use to hone their skills.

In honour of their 50th anniversary, the Class of 6T1 gave a student award to support the next generation of nurses.

Breakfast with the Dean

In early October, acting dean Linda McGillis Hall welcomed the 170 students starting the bachelor of science in nursing program. The breakfast gave the students an opportunity to ask McGillis Hall questions about Bloomberg Nursing, and McGillis Hall the chance to meet individual students.

Our two-year undergraduate nursing program is designed for those who already have at least 10 university credits. Entry into the program is highly competitive; most of our first-year students have an undergraduate degree, and many have earned a graduate degree.

Students have begun our nursing program with everything from an undergraduate degree in political science or zoology, to a master’s degree in

5 Years Out, 50 Years Out

We all started at the University of Toronto’s nursing program, but where we ended up – well, who could have guessed? A U of T nursing degree can take you around the world, or lead you right back home.

5 Years Out: Erin Vandeven Soble earned a BScN in 2006 and then completed her master’s degree this past spring. A neuroscience and trauma nurse at the Hospital for Sick Children, her passion for paediatric nursing has fostered interests in undergraduate nursing education, paediatric pain management and the nursing role in international health development.

Recently, she presented an abstract on an appraisal of halo pin site literature at the Canadian Association of Neuroscience Nurses scientific sessions in Vancouver.

Vandeven Soble enjoys volunteering as a nursing preceptor with the U of T
Canadian literature. “With so many diverse backgrounds, our students bring a wide range of perspectives and talents to nursing,” says McGillis Hall.

Alumni Learning Series off to a great start
This fall, Bloomberg Nursing welcomed alumni to the first two presentations in its lunchtime learning series. Professors Amy Bender, PhD 0T9, and Jan Angus, BScN 7T8, each gave an intriguing lecture and fielded questions from the alumni who attended.

Bender described the Ethiopian Canadian Nursing Collaboration and the e-mentoring initiative that pairs nursing academics and advanced practice clinicians in Toronto with master’s students at the nursing school at Addis Ababa University. The partnership is helping build research capacity among the nursing leadership of Ethiopia.

Angus researches the contextual influences on health-related decisions and practices. In her presentation, she described the multiple strategies that participants in cardiac rehabilitation programs use to incorporate new health behaviours.

We have a winner!
Congratulations to Peter Burns, BScN 0T4, who won Pulse’s lucky draw.

Something we already know about our readers is that they’re busy. To encourage the readership to respond as they fly out the door, we offered to enter all of the reply cards in a draw for a $150 Future Shop gift card. We trust that Burns, an NP at Windsor Regional Hospital, has put the card to good use.

Professors at top of the class
Every fall, Bloomberg Nursing recognizes some of its A+ professors with a teaching award. Among the 13 honoured teachers this year is Willi Kirenko, MN 0T6, who for the second year claimed the Excellence in Online Teaching Award for demonstrating innovation, enthusiasm and critical thinking in developing online components of the NP programs. The awards also recognize teaching assistants who effectively bridge the gap between instructor and students, and this year’s winner is Maki Iwase, BScN 0T0.

student clinic IMAGINE (Interprofessional Medical and Allied Groups for Improving Neighbourhood Environment). In this role, she mentors students in the care of vulnerable populations.

This fall, she began yet another new role: as a lecturer in the undergraduate program at Bloomberg Nursing.

50 YEARS OUT: Before Elaine Atkinson Broderick, BScN 6T1, moved to the U.S., she was a surgical nurse at Mount Sinai Hospital and on the faculty of the Nightingale School of Nursing in Toronto. She also helped proofread a textbook by Helen Carpenter, a former director of U of T’s nursing school.

When Broderick moved to Greenville, S. C., in 1974, the state wouldn’t recognize her degree. “This is a state that had health care that ranked at the bottom of all the states!” she exclaims. “There was much to be done, so I decided to volunteer.” Since individual schools didn’t have a nurse, Broderick trained mothers in first aid who then volunteered at the local school. And along with two neighbours who were nurses, she developed a substance abuse prevention program for Grades 1 to 5.

In 1984, Broderick took the state board exam and registered as a nurse. For nine years, she was an American Red Cross bone/tissue transplant co-ordinator, often being on call 24 hours a day, seven days a week. “It was exhausting yet extremely rewarding,” she recalls.

In 1995, after earning a master’s in nursing at Clemson University in South Carolina, she accepted a full-time position teaching nursing fundamentals at Greenville Technical College. Although Broderick officially retired from the college in June 2009, she still works part-time there and is an adjunct faculty member on the faculty senate.

In addition, Broderick is the board chair of a federally funded community health centre that serves those without medical insurance. “The centre is a valuable community entity in this time and place,” she says. “My education at U of T prepared me to be versatile, confident and flexible in the paths I followed,” she continues. “The rewards, relationships and personal satisfaction nursing has brought to me are immeasurable.”
New: NP Global Health Care Program

In September, Bloomberg Nursing introduced the innovative Nurse Practitioner Primary Health Care – Global Health stream to its master’s of nursing and post-master’s diploma programs. The new practice-focused program offers students the opportunity to focus on global health issues in Canada and around the world from a primary care perspective.

Students in this stream study the health care needs of clients of all ages – from newborns to the elderly. They examine global health care from a primary health care perspective, including social determinants of health, millennium health goals, health promotion and prevention, as well as how to be an effective practitioner and consultant in countries that have a developing economy. In collaboration with Bloomberg Nursing’s participating partners, clinical placements will be offered in First Nation communities across Canada, in settings that serve immigrant and refugee communities, and in other settings that promote a global perspective.

This groundbreaking program is in addition to Bloomberg Nursing’s three other NP programs, which are in adult, paediatric and anaesthesia care.

We’re on Twitter!

Follow Bloomberg Nursing on Twitter. Learn about courses for practising nurses. Discover awards you can nominate your colleagues for. Celebrate the successes of our faculty and students. Be the first to hear about newly published materials. Follow us @UofTNursing.

Rob Fraser
How to Blog and Tweet
Master’s student writes social media guide for nurses

In Grade 10, Rob Fraser started watching podcasts of university lectures from Stanford and Yale on his iPod. When he decided to become a nurse, he wanted to watch podcasts of nursing lectures. There weren’t any.

One reason for this void, says Fraser, is the overemphasis on the risks of social media and not enough information about its advantages. “Facebook and Twitter are just tools,” says Fraser, who is in the administration stream of our master’s program. “Social media provides exciting possibilities for networking, and finding and sharing information. Every profession has to keep up with communication or risk missing opportunities.”

Scheduled to graduate from Bloomberg Nursing this fall, Fraser has already taken a leadership role by becoming a social media activist for nursing in Canada. His recently released book, The Nurse’s Social Media Advantage: How making connections and sharing ideas can enhance your nursing practice, is the only book on the topic tailored specifically to nurses. The guidebook tells you how to navigate everything from Facebook, to Twitter, LinkedIn and blogging. Published by Sigma Theta Tau International, it also explains how social media can be used to advance a nurse’s career and the nursing profession.

In her endorsement of the book, Judith Shamian, Bloomberg professor (status) and president of the Canadian Nurses Association, wrote, “If the words ‘social media’ sound like words from another language, then this book will serve as a translation tool.”

In 2008, Fraser launched the nursingideas.ca website.

To order The Nurse’s Social Media Advantage, visit snipurl.com/nsmaca.
A CHAMPION OF SLEEP FOR MOTHERS-TO-BE
The Ontario Ministry of Research and Innovation has presented Robyn Stremler, PhD OT8, with an Early Researcher Award. The Bloomberg assistant professor is investigating the prevalence of and risk factors for sleep disturbance during pregnancy.

The award will help fund the education of the next generation of sleep scientists in Ontario, a field in which nurses are under-represented. Over the five years encompassed by the award, a number of undergraduate and doctoral students will be provided the opportunity to collect and analyze sleep data using actigraphy, a non-invasive device that measures sleep.

Stremler, a Canadian Institutes of Health Research (CIHR) New Investigator, is the principal researcher for the Sleep TYME (Throughout Your Motherhood Experience) Study.

ALPHA, BETA, GAMMA, DELTA
The Sigma Theta Tau International (STTI) Honor Society of Nursing, Lambda Pi At-Large Chapter, has honoured two Bloomberg Nursing faculty members and one recent graduate.

Kate Hardie, BScN 7T5, MScN 8T2, our undergraduate program chair, was selected for the Award for Excellence in Nursing Leadership. This award acknowledges Hardie’s contributions in enhancing the quality of nurses’ work environment through innovative nursing practices.

Monica Parry, PhD OT8, the director of nurse practitioner programs, received the Dorothy M. Pringle Award for Excellence in Nursing Research. Parry is also a cardiac care nurse, and one of her studies involves using impedance cardiography to improve health outcomes in individuals with heart failure.

Margaret Saari, BScN 1T1, earned the President’s Award for Outstanding Leadership by an Undergraduate Student. Saari was a team lead for a quality improvement project at Mount Sinai Hospital and a member of the quality improvement team at the Hospital for Sick Children.

COMPASSIONATE CARE
Congratulations to Ashley Bowering and Jennifer Canning, both BScN 1T1, who each received a Sopman Humanitarian Award for the understanding and support they offered while providing patient care. Archie Sopman initiated the award to recognize the kind, gentle care that a student nurse gave his wife.

FOR IMPROVING CLINICAL TRIALS
The Society for Clinical Trials selected Julie Weston, BScN 7T6, to be a Fellow. Weston is only the second nurse and second trial coordinator to receive this honour. The Society established the title in 2006 to recognize individuals who have advanced clinical trials.

Weston is a senior trial co-ordinator in the Randomized Controlled Trials Unit at Bloomberg Nursing.

HISTORIC AWARD
Congratulations to Jaime Lapeyre, BScN 0T4, MN 0T5, PhD (cand.), who received the Alice Fisher Society Fellowship for Historical Research in Nursing. For her doctorate, Lapeyre is researching the development of leadership roles in the first half of the 20th century.
There is no training manual on how to teach nursing through simulated clinical scenarios. The instructors need to script situations through which students can develop clinical reasoning and master nursing skills. They also need a flair for acting to make the scenarios believable. Acting and playwriting are not core competencies for nurses, and to teach through simulation you also need a good grasp of its educational objectives and excellent debriefing skills. But Maureen Barry, MScN 8T7, simulation lead for Bloomberg Nursing’s Simulation Laboratory (Sim Lab), says her team has it all.

Take lab instructor Sarah Johnston, MN 0T7, who draws on her experience as a trauma and neurosurgery nurse to make the scenarios come to life. Barry says Johnston excels at adding props – such as a glass of juice at the bedside – that add required realism.

**CODE BLUE, CODE BLUE**

Walk into the Sim Lab and you would think it’s a real hospital. The lab has a 12-bed ward, intensive care area, isolation room and operating room with a post-anaesthesia care unit. To further simulate a hospital setting, a mock code is occasionally announced over the intercom.

Undergraduates begin using the lab in their first week of classes, and simulation is integrated into all of their clinical courses. The lab is also used in a community health course, the nurse practitioner program and some Centre for Advanced Studies in Professional Practice (CASPP) courses.

“In the lab, it’s not passive learning like in a traditional classroom,” explains lecturer Jennifer Macauley. At first, students can be disarmed when they realize they have to actively engage in a scenario, but soon realize the benefits.

**GOOD MORNING MR. ROBINSON**

The medical mannequins of yester-years were great for practising simple procedures, such as positioning a patient in bed. Today’s high-fidelity mannequins are used to learn much more complex procedures, such as blood transfusion reactions, because they can relay symptoms and respond to the students’ interventions. The Sim Lab’s mannequins have a heartbeat you can hear with a stethoscope. Their chests rise and fall with each breath.

The pretend patients also seem to speak. An instructor gives the mannequin its voice by talking into a microphone in the control room. Or, she stands behind a curtain with a microphone to speak for the patient.

Macauley starts off a simulation by saying, “Strangely enough, this mannequin will have an Australian accent.” She brings her experience with the nursing simulation lab at the University of Notre Dame in Sydney to the team.

To help develop the mannequin’s character, the instructors create cos-
The use of mannequins, such as Mrs. Chase, above, isn’t new to nursing education. For decades, proxy patients have enabled nursing students to practise their clinical skills without risking client safety. These much-loved mannequins never once complained despite myriad treatments and the occasional tumble onto the floor.

The students enter the scenario and ask Mr. Robinson how his night was. “I’m not feeling well,” answers Mr. Robinson. (It’s really Johnston speaking in a deep voice.) The nursing students then start a physical assessment; some assess vital signs immediately, while others begin by asking Mr. Robinson more specific questions.

LIGHTS! CAMERA! ACTION!

“This is a classroom, and we work hard to make it a safe environment for learning,” says Macauley. “In the debriefing session that follows each scenario, we never tell students what they should have done. Instead we ask, ‘Is there anything you would have done differently? What were you thinking when you decided to check his pulse at that time?’”

All simulations can be filmed so students can review their performance later. “In the heat of the moment, the students forget they’re working with a mannequin,” says Barry.

The team is looking forward to the return of instructor Jordanna McMurray, who is on parental leave. “She’s wonderful at developing paediatric scenarios,” says Barry.

Left to right:
Maureen Barry (left) with Jennifer McCauley (centre) and Sarah Johnston.
A view from the Sim Lab’s control room.
A high-fidelity mannequin awaits treatment.
Time Travel

In 1958, Professor Margaret Allemang conducted what was likely Canada’s first clinical research project. Not that it was her idea. Nettie Fidler, the director of U of T’s nursing school at the time, urged Allemang to conduct a study because she needed research activity to start a master’s program. There was one big problem. “I didn’t know what to do,” recalled Allemang in a 1993 interview.

Although Allemang completed three U of T nursing programs – earning a Certificate in Public Health Nursing 4T0, BScN 4T7 and Certificate in Nursing Education 4T8 – research had never been in the curriculum. But while studying at the University of Washington in Seattle, she had learned enough about research methodology to develop an observational study. She focused on the experiences of eight cardiac patients at Toronto Western Hospital.

For the study, our nursing school and Toronto Western each provided eight observers who took turns sitting at the patients’ bedsides day and night, documenting and timing every interaction. “I remember going almost crazy counting the minutes,” recalled Allemang. “And I remember the night nurse had all her keys hanging from her waist and they would jingle, jingle, jingle.

“One of the findings was that the nurse wasn’t really with the patient very long,” she continues. “But that was 1958.”

Allemang’s research was well received and contributed to the launch of our first master’s program in 1970. After teaching at U of T from 1951 to 1982, Allemang went on to found the Ontario Society for the History of Nursing, which was later renamed in her honour. Visit the Margaret M. Allemang Society for the History of Nursing website at www.allemang.on.ca.

After graduating from U of T in 1940, Margaret Allemang became an assistant head nurse on a cancer ward at Toronto General Hospital. The position was partly funded by our School of Nursing to break down prejudices against university-prepared nurses and demonstrate how capable they were in all fields of nursing.
Celebrating our 2011 Graduates
Prior to convocation, Bloomberg Nursing will host a reception for its 2011 BScN graduates. Each grad may invite two guests to the event. The reception will be in the Music Room at Hart House, from 2:30 to 4:30 p.m.
To Learn More: Contact the Alumni Relations Office at development.nursing@utoronto.ca or 416.946.7097.

Alumni Lifelong Learning Series
Professor Doris Howell, MScN 8T3, discusses the use of a mixed-method study to address gaps in chronic disease self-management. The RBC Financial Group Chair, Oncology Nursing Research and Education, researches psychosocial responses to cancer. To develop self-management interventions, Howell explores how the perception of complex symptoms affects symptom outcomes and health behaviours.
This is the last in the 2011 learning series, and attendance is exclusive to U of T nursing alumni. Noon to 2 p.m.; lunch is included.
To Learn More and Register: Email development.nursing@utoronto.ca or phone 416.946.7097.

Course: Clinical Teaching
In this Centre for Advanced Studies in Professional Practice (CASPP) course, the faculty will focus on the scholarship and the art that support successful, creative clinical teaching. The increasing complexity of clinical environments for nursing student education creates unique challenges for both seasoned and novice clinical teachers.
To Learn More and Register: bloomberg.nursing.utoronto.ca/CASPP.

National Institute on Nursing Informatics
This three-day institute led by Lynn Nagle, MScN 8T8, will provide a broad introductory curriculum in informatics to equip you with the foundational knowledge you need to effectively participate in operational and educational activities in your practice setting. An international faculty will present didactic, group and self-study learning opportunities. To ensure a focused experience, registration is limited.
To Learn More and Register: bloomberg.nursing.utoronto.ca/CASPP.

Integrating New Nursing Graduates Into the Workforce
Nurse leaders: ensure long-term retention of your new nurses. This one-day event provides the latest research on new graduates in Ontario, as well as strategies for the development, implementation and evaluation of integration programs. It highlights evidence that supports best practices in the initial integration of new graduates into the practice setting. As well, there are discussions on preceptorship and the innovative practices at academic health care organizations in Toronto.
To Learn More and Register: bloomberg.nursing.utoronto.ca/CASPP.

Course: Preparing for the RN(EC) Adult Exam
Learn from nurse practitioners who have successfully written the American certification exam for adult health care. This course enhances your content knowledge and helps you develop approaches to answering multiple-choice questions. It also assists by identifying the areas you need to concentrate on prior to writing the ANCC exam.
To Learn More and Register: bloomberg.nursing.utoronto.ca/CASPP.

Course: Preparing to Write the CRNE
In this Canadian Registered Nurse Exam (CRNE) preparation course, you review the exam structure, study approaches to answering multiple-choice questions, and develop strategies for learning the required information on medications, laboratory results and diagnostic tests. The second day includes a four-hour mock CRNE, which is graded to help you identify areas requiring additional study. This course is also offered in Alberta.
To Learn More and Register: bloomberg.nursing.utoronto.ca/CASPP.
Welcome to the Centre for Advanced Studies in Professional Practice

Be an innovator. Lead practice change.

The Lawrence S. Bloomberg Faculty of Nursing Centre for Advanced Studies in Professional Practice (CASPP) offers opportunities for nurses and other health care professionals to expand their knowledge in clinical practice, education, leadership, research and informatics.

Our faculty of outstanding clinicians, researchers and educators draw on the latest research and scholarship to provide thought-provoking programs that will advance your skills, support practice development and enhance your career.

Join us for a CASPP course or workshop, and become part of a growing network of thought leaders in health care.

For a list of CASPP's upcoming professional development programs and exam preparation courses, refer to Events on page 29 or visit bloomberg.nursing.utoronto.ca/CASPP.

Follow us on Twitter @UofTNursing