It’s Time for a CHANGE: Nurses Take up the CHALLENGE
Margo McCutcheon initially studied nursing to qualify as a flight attendant. “I belong in the sky,” she says. Eventually Mrs. McCutcheon, BScN 6T4, became a pilot, and credits her nursing education for giving her the confidence and interpersonal skills to follow her dream.

Nisa Mullaithilaga wants nothing more than to be a paediatric nurse. But after earning an undergraduate biology degree and then a master’s degree in pathology, she wondered if she should assume more student debt. With the help of generous alumni, such as Mrs. McCutcheon, Nisa excitedly started U of T Nursing this fall.

To find out how you can help deserving students, contact your alma mater at development.nursing@utoronto.ca or 416.946.7097.
Contents

FEATURES

Finally! We’re Singing in Unison ........................................ 3
The social determinants of health now have a fresh,
compelling tune by Dean Sioban Nelson

Time to Listen ............................................................. 6
Bloomberg Nursing’s Aboriginal placements are
community centred and community led

Who Shouldn’t Stay in the ICU? ..................................... 10
The possibility of weaning from a ventilator decreases over time

Meeting Clients Where They Are .................................. 12
To reach those who refuse services, be present with the
right attitude

Colour Me Invisible ...................................................... 14
Among Toronto’s most vulnerable are those who work in
the shadows as undocumented migrants

Falling Through the Cracks .......................................... 17
Patient information can go astray when clients are
transferred to a new facility

DEPARTMENTS

Dean’s Message ............................................................ 2

Opinion ........................................................................... 20
In “Nursing in Canada Comes of Age,” our Distinguished Visiting
Professor Tom Keighley charts how it takes nurses to make the
difference

News .............................................................................. 22

Q&A .............................................................................. 25
A conversation with Dr. Arlene Bierman, the principal investigator
of the POWER study and a Bloomberg Nursing associate professor,
who shares her insights on health inequity among the elderly

Time Travel .................................................................... 26
The colour barrier couldn’t stop these women from nursing
in Ontario

Events ........................................................................... 29

Cover: Geoff Ford, BScN OT9, in an alley near East Hastings Street, Vancouver.
Ford is helping to prevent the spread of HIV by offering outreach services
to some of the city’s most marginalized populations.

Photo: www.kaico.ca
These are the billion-dollar questions that researchers, health professionals, policy-makers and governments are asking today. They’re asking these questions near and far, from our local health centres in Toronto, to Ottawa, to the EU, to Geneva. There is a growing sense that time is running out for the health care systems built around the doctor’s office and the hospital that we’ve had since the mid-20th century. But what next?

This issue of Pulse joins in the debate with a collection of compelling stories about students, faculty and alumni who are tackling these hard questions. By focusing their energy where it’s needed most, they’re bringing solutions to some of our most challenging patient care and population health issues.

Assistant Professor Louise Rose’s research and clinical work with long-term ventilated patients, for example, showcases strong science and a depth of clinical knowledge. Her contribution to the lives of these patients and their families is immense. And her work is pointing out how to save the system scarce human and financial resources.

Likewise, doctoral candidate Krista Keilty’s work with technology-dependent children and their families highlights the value of advanced practice nurses developing a program of research that arises out of their clinical practice. Krista has worked with this population for many years, piloting the first program for technology-dependent children and their families in Ontario. Now her research aims to improve the quality of life of these parents by addressing the exhaustion they typically suffer.

Associate Professor Denise Gastaldo’s work shines a light on a seldom-discussed vulnerable population, Canada’s undocumented workers. Without access to health care services, the plight of these individuals is serious and little understood. Gastaldo’s creative research approach provides a powerful visual narrative of dislocation, health, work and identity.

Alumnus Geoff Ford works to bring into the system another marginalized, excluded community: HIV-positive men with mental health and addiction challenges. From outreach clinics in Vancouver, he focuses on building trust and supporting clients to enter HIV treatment programs.

Health care for this century will need to look very different from that of the past. We know more about disease and ill health than ever before. We also know the solutions are more often than not found outside of the health care system. But what these stories show us is that there are better ways, and nursing researchers and clinicians are finding them. The beneficiaries of creative and focused approaches to so-called intractable problems are the patients or clients, the system and the bottom line. What could be better than that?
WE’RE SINGING IN UNISON FINALLY!

The social determinants of health now have a fresh, compelling tune

by DEAN SIOBAN NELSON, RN, PhD, FCAHS
It's the same old song, and policy pundits have been singing it since 1974 when Marc Lalonde, Canada's health minister, released a report that set out a manifesto for health transformation. The Lalonde Report is considered the first government document in the Western world to acknowledge the need to look beyond traditional health care to improve the public's health. It broadcast the message that health is not a product of the health care system. It declared that only a healthy society can produce health. Schools, housing, employment, communities and myriad other issues unrelated to health care are what create health – and ill health.

No less than 75 per cent of the determinants of health are extrinsic to the health care system. What health care does is treat the symptoms of socially produced ill health. Even the success of these treatments falls along the predictable gradient of income; those with a lower income experience poorer treatment outcomes.

In the 38 years since Lalonde's report, governments and service-planners have made only incremental efforts to change a health care system designed and built to deliver acute care. This tinkering around the edges of the system has failed to impact the growing tide of poor health around the world. Just five chronic diseases – more correctly termed non-communicable diseases (NCDs) – are projected to cost a staggering $47 trillion globally over the next 20 years. And we're just at the beginning of the demographic shift that will send both the number of people with NCD and health care budgets into the stratosphere. Importantly, this is money not being spent on education, housing, clean water, food security, community development, green energy – the real solutions to poor health.

A MODERN MELODY
But now the social determinants of health have a fresh, compelling tune. And you can hear this contemporary song everywhere!

In 2008, the WHO Commission on Social Determinants of Health released its final report on reducing health inequities by addressing the health determinants. Calling for widespread system transformation along a set of core priorities to build and protect the most vulnerable, the WHO report commenced a cascade of other reports around the world.

In 2009, the Institute of Medicine in the U.S. released “A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety,” a report by the Prevention Institute. It set out a four-pronged approach to transformation that involved community, health care, as well as system and overarching strategies. It also noted a disturbing research finding: for every $12,500 in income difference between families in Alameda County, California, people in the lower-income families could expect to die a year sooner. The report went on to say that this is the jarring reality across all of America.

One year later, Sir Michael Marmot released “Fair Society, Healthy Lives.” This report was commissioned by the British Labour government but endorsed (remarkably) by the incumbent Conservative government as central to improving the health of the British. It names a more just society as critical to reversing the overwhelming burden of disease that’s crippling health care systems and government budgets alike.

Closer to home, the Association of Ontario Health Centres recently released the discussion paper “An Emerging Primary Health Care Strategy for Ontario.” Also this year, Toronto Central LHIN in its new strategic plan called for a renewed focus and emphasis on the top one per
cent of users of health services, and the most vulnerable individuals and communities. Both documents emphasize broadening the view beyond the health care system to team-based care in which all of the team members work to their full scope of practice.

The Canadian Nurses Association and the Canadian Medical Association chimed in on the chorus by creating a powerful coalition to lobby for system transformation at the national and provincial levels. This alliance brings together doctors and nurses from across Canada who in one voice call on first ministers, health ministers and politicians of every stripe. They’re lobbying for Canada’s health care system to move from one that focuses on episodic treatment-focused care to one that tackles the deeply rooted challenges of poverty, social disadvantage, racism, marginalization and the other social determinants of health.

**A CALL TO NURSES**

In 2011, CNA took this agenda one step further. It established a National Expert Commission co-chaired by Marlene Smadu, a former CNA president, and Maureen McTeer, a lawyer and leading health advocate.

The Commission, on which I was privileged to sit, took these international reports as its starting point. It then asked Canadians what they want and need in their health care system, and what role they want nurses to play in creating that system. The Commission released its report, “A Nursing Call to Action: The Health of Our Nation, the Future of Our Health System,” at CNA’s biennial meeting in June.

The report proposes a bold agenda for nursing to lead and drive the fundamental transformation of the system. With Canada slipping down the ladder on many health measures (except cost), the Commission challenged nurses to mount a campaign to reverse this downward trend and give the country something to celebrate on its 150th birthday in 2017. The first item in the nine-part plan calls for Canada to step up, aim high and be one of the top-five countries in five health outcomes in five years.

To achieve this ambitious goal, the Commission believes nurses need to direct their energy and creativity where nursing interventions are known to be most effective. These are the very areas where the system is the least successful in meeting the needs of individuals, families and communities. Let me explain.

**WHO THE SYSTEM FAILS**

More and more data is emerging about the high health-care dollars being spent on the top one and five per cent of system users. Who are these users who fill the emergency rooms, doctor’s offices and hospital beds? Frequently, they suffer from a multitude of chronic diseases as well as mental health and addiction challenges. They are socially marginalized and poor. Overrepresented are children, people with a physical and/or mental disability, the very old, the marginalized and the racialized. Our current acute care, episodic-focused system is failing these individuals and communities. The solution to this seemingly intractable problem is not more doctor office hours, more doctors and nurses, or more dollars for providers.

What we need for these health care users is a new model; one that nurses are perfectly equipped to lead. To start, we need to move from the acute care system and be in people’s homes, on the streets, in the schools and in the shopping centres. We need to be everywhere people are. Does this sound like a pipe dream? Think again.

**LOOK NORTH FOR INSIGHTS**

An inspiring member of the Commission was a Métis nurse practitioner: Julie Lys from Fort Smith, Northwest Territories. In this community, a 1,350-kilometre drive north of Edmonton, local primary health nurse practitioners, midwives and other nurses took matters into their own hands and created a health care team that is flexible and responsive to the community. It’s highly integrated with the schools and social services, and through telehealth connects with specialist health services thousands of kilometres away. It works with traditional healers to support clients, and also offers palliative care in the community and in their small hospital.

The team successfully transformed a broken system fixated on trying to attract doctors to Fort Smith and maintaining a medical model of care. For years, the community worked with locums who flew in and out of the community every few weeks. There was no continuity, no partnering with the community on health issues, no working closely with individuals to manage chronic conditions and heal the traumatic effects of colonialism and residential schools.

Today, the team has a nurse-led youth health clinic in the high school to support teen health and wellness. And recently, it engaged two permanent physicians who will help to ensure that the best possible care is provided to the community’s 2,500 residents.

Fort Smith teaches us two lessons: 1) it is possible to do it right, and 2) nurses need to see beyond the walls of what the Economist described as the “legacy” system of contemporary health care. While the health care system may have been a great leap forward after the Second World War, it’s now sinking $200 billion a year in Canada alone while reaping increasingly poorer returns on taxpayer investment. More hospitals, more clinics, more doctors and more nurses will not dint the demand for health care if we don’t tackle the source of the problem. What’s indisputable is that more of the same will bankrupt us.

If nurses take up the challenge to change the system, they’ll need to be prepared to change themselves as well as their practice. The question we all need to ask is: What does every community need to be healthy? Then we must demand that our politicians have the courage to listen to the answer.
Working with Community: The next generation of nurses and Aboriginal health

Weeneebayko General Hospital in Moose Factory in northern Ontario offers placements to Bloomberg Nursing undergraduate students in their final year.
“No group in Canada suffers greater discrimination and ill health than our Aboriginal people,” reports CNA's National Expert Commission. “On reserves, many live in Third World conditions, while in cities many live on the street, without jobs, education or hope.”

Nurses are responsible for much of the health care of First Nations, Inuit and Métis people, especially in isolated northern communities. The responsibility to prepare nurses to help fulfil this need is one that U of T Nursing takes very seriously.

Lecturer Pamela Walker, BScN 8T9, who practised in Aboriginal communities for 18 years, leads our undergraduate Aboriginal health initiatives. Walker is adamant that members of the Aboriginal community teach our undergraduate students about Aboriginal health, both in the classroom and in clinical placements. “In our colonial practices, Western people told the Aboriginal community what it needed, and that hasn’t helped. Now we need to listen to the community’s leaders and elders who know what their people need, and support what they feel is important for their future,” she says.

PROTECTING ABORIGINAL CULTURE
All first-year students attend a seminar taught by Anishnawbe Health Toronto. This Aboriginal organization – formed in response to culturally insensitive health care as well as subtle and overt racism – offers a cultural safety seminar to health science students in Ontario.

The Indigenous Physicians Association of Canada developed the award-winning two-hour module that’s presented at U of T Nursing. In this session, an Aboriginal preceptor who is a community leader describes indigenous worldviews; the impact of the Indian Act and the intergenerational effects of residential schools, colonization and systemic discrimination; as well as the concept of health and healing in an Aboriginal context.

“Last year, the students just burst out of the classroom after the presentation,” recalls Walker. “They were so excited by what they had heard and were still talking about it months later.”

URBAN OPPORTUNITIES
More than half of Canada’s Aboriginal population live in cities, and our undergraduate program offers a variety of placements with Aboriginal organizations in Toronto in its senior-year community
health course. The students who choose the Aboriginal Health Section have the opportunity to be preceptored by experienced frontline workers from the Aboriginal community.

At the First Nations School of Toronto, for example, the preceptor is an Aboriginal teacher. In this 84-student school that offers kindergarten to Grade 8, the Bloomberg Nursing student concentrates on health promotion and the social determinants of health, such as healthy foods and regular physical activity. “Our students learn how to promote health and provide culturally safe, holistic nursing care,” says Walker.

New this fall are placements with the Native Women’s Resource Centre, and Native Child and Family Services of Toronto. Bloomberg Nursing students have the opportunity to work directly with Aboriginal women and families. They’re preceptored by Aboriginal staff, including a midwife, outreach workers and a housing co-ordinator. Students participate in cultural events and learn how important traditional Aboriginal health practices are to healing within the community.

The Native Men’s Residence and Toronto Council Fire Native Cultural Centre are Aboriginal service providers that address the social, health, education, economic and cultural needs of Toronto’s native population. In these placements, students are preceptored by Aboriginal nurses. “This is a real privilege for students and faculty, given that there are so few nurses of Aboriginal ancestry in our profession,” Walker says.

Other placements involve working with Aboriginal preceptors in advocating for safe, affordable housing and other social determinants of health. Nursing students advocate alongside clients to handle conflicts with landlords, and join the efforts of the larger Aboriginal community in addressing issues such as homelessness, poverty and unemployment. They may also offer one-on-one support to individuals in vulnerable situations, offering to accompany them to medical, legal, child welfare or other appointments.

OUTWARD BOUND
The final degree requirement for undergraduate nursing students is a 10-week clinical placement.

Students can fulfill this requirement in Toronto or in one of myriad settings across Canada. There are several Aboriginal settings, including Sioux Lookout Meno Ya Win Health Centre, a 54-bed acute-care facility with a 20-bed extended care facility in northwestern Ontario; and the Marie Adele Bishop Health Centre in the small community of Behchoko, Northwest Territories.

All of the students who participate in the Aboriginal Health Option for their final practicum attend four seminars to prepare them for the experience and further introduce them to the challenges that affect Aboriginal health. Walker holds each seminar at U of T’s First Nations House, which provides culturally supportive services and programs for Aboriginal students and the larger university community. At the seminars, they share a meal and converse with a guest speaker, such as a traditional teacher, Aboriginal nurse, health consultant or elder.

By collaborating with the university’s Aboriginal community, U of T Nursing students have the opportunity to speak with students who grew up on a reserve and have experience with a traditional healer. “I really want people other than myself to inform the perspective of the students,” says Walker.

AT THE GRADUATE LEVEL
In 2011, U of T Nursing introduced the Primary Health Care-Global Health (PHC-GH) emphasis to its nurse practitioner program. As is required to enter all of our NP programs,
**Rising to the challenge**

Alex Teleki, BScN ’10, is in the final stages of earning a master’s of public health. As well, he is practising as a relief nurse at health stations in northern Ontario, Manitoba, Nunavut and the Northwest Territories. Previously, he served for 18 months in northern Ontario at the Attawapiskat First Nations Reserve, which is experiencing a major housing crisis.

**What inspires you to be an outpost nurse?**
Many reasons, but one is a sense of solidarity. I have done international work in developing countries and wanted to use my skills to contribute to my own country in places that need them most.

**How is Attawapiskat’s housing crisis affecting health?**
Most of the houses have black mould, which has been linked to reactive airway disease and asthma, and is especially dangerous for young children and the elderly. And many homes are heated with wood, which creates the potential for smoke-related respiratory issues.

The most important housing issues, though, are not strictly medical. Imagine a family with a baby living in a complex with over a hundred people and one bathroom. Imagine a family of six living in a tent with no bathroom. In situations like this, dignity is an issue. People need space for development, for studying, resting, privately performing activities of daily living and intimacy. And the need for private space is magnified when the temperature drops to 50-below. Having a place to call your own is a big deal.

**What health concerns did you encounter?**
Never before have the social determinants of health been so clear to me. I could see how isolation combined with inadequate nutrition, housing, water and employment all contribute to diabetes and heart disease, which are the biggest health problems.

There are also a lot of skin disorders, such as infections and eczema, as well as mental health issues, including depression and schizophrenia, which can lead to suicide. Substance abuse is widespread and can result in trauma. Not to be forgotten is abuse, including sexual abuse, a difficult topic made even more difficult by the history of abuse in the residential school system.

**What is your most vivid memory from Attawapiskat?**
In the middle of the night, an expectant woman came into the clinic and started to deliver before I could call for support. Expectant women are usually sent out to deliver, but the baby obviously didn’t know the protocol. Worse yet, the baby wouldn’t come out because of its position and size. When the infant was finally born, it was my worst nightmare; he was blue and flat. “That’s it,” I thought.

In the South, there is always someone to turn to. In the North, you can’t just pass the buck. You may be all that stands between a patient and a terrible outcome.

I finally got the baby to breathe by starting bag mask ventilation with supplemental oxygen, and eventually a Medevac arrived. When the mother and baby were airlifted out, my knees felt weak and I didn’t know if the baby was going to be OK.

A few weeks later, the mother came into the clinic carrying her baby. They were both healthy and smiling. The mother left the baby in my arms so another nurse could give her a postpartum check. I couldn’t help but tear up.

Students must be an RN with a minimum of two years experience. PHC-GH started with 13 students, and then this fall enrolled more than 20.

“There is a lot of competition to get into the PHC-GH emphasis because our program is unique,” says Naomi Thulien, the co-ordinator. “One of the things we look for in applicants is that they have already displayed a strong commitment to working with vulnerable populations, either in Canada or overseas.”

Walker introduced Thulien to Aboriginal Health Access Centres (AHACs), which are community-led, primary health care organizations. NPs run most of the 10 AHACs in Ontario, some of which are on reserves. Our PHC-GH learners who choose this practicum develop an understanding of Aboriginal traditional healing, as well as have the opportunity to practise in conjunction with a variety of social services, including health promotion initiatives and a youth empowerment program.

“Some of these patients are very complex because they have many needs,” says Thulien. “A woman may come in with an earache, for instance, but in the course of the assessment you may learn that her family is facing food insecurity and could be helped by being directed to a food bank. There may be questions about accessing appropriate social supports or finding help with employment.”

“There’s a huge need to learn how to provide health services and advocate for vulnerable populations in ways that are empowering and sustainable,” continues Thulien, who helps run mobile medical clinics in rural Honduras and Haiti. This year, some of the PHC-GH students will have the opportunity to join Thulien overseas.

Many people are so overwhelmed by the needs of vulnerable populations, such as Canada’s Aboriginal peoples, they don’t try to help because they don’t even know where to start. “Listening is the place to start,” says Walker. “It is an honour to hear someone’s story. Taking the time to sit and listen to their story shows respect. You can ease their suffering in that moment by listening.”
Who shouldn’t stay in the ICU?

Assistant Professor Louise Rose’s research is helping inform health care planning for individuals who require mechanical ventilation. What she’s proposing will not only save the health care system money, it will vastly improve patient care.

One of Louise’s current research programs is based at the eight-bed Provincial Centre for Weaning Excellence at Toronto East General Hospital, known locally as the Prolonged-Ventilation Weaning Centre (PWC). The Centre’s vision statement is: No long-term ventilation patients in any intensive care unit in Ontario. That pretty well sums up Louise’s research conclusions. “These patients should not be in an ICU,” says Louise Rose, who held U of T Nursing’s inaugural appointment as the Lawrence S. Bloomberg Limited-Tenure Professorship in Critical Care.

PWC serves ICU patients who have recovered from an acute illness, have been on a breathing machine for longer than 21 days and want to try breathing on their own. “The aim of the game is always to get the patients off mechanical ventilation,” she says.

NEEDED: SYSTEM CHANGES
This year, the Canadian Respiratory Journal published a retrospective study of PWC that Louise Rose conducted with Dr. Ian Fraser, one of the Centre’s four respirologists. The study pointed out that unlike in the U.S., Canada’s health care system doesn’t have financial incentives to transfer patients out of the ICU after 21 days of ventilation. Without a system in place to promptly move patients from the ICU when they no longer need constant, close monitoring, patients can spend more than four times longer in the unit. The study found that PWC patients had been in the ICU on ventilation much longer than 21 days. They were in the ICU for 37 to 89 days.

There are clear financial benefits to moving stable patients out of the ICU and into a weaning centre. The cost of caring for a patient in the ICU is two to three times greater than it is in the PWC.

An even more important reason for a speedy exit from the ICU is that the possibility of weaning from a ventilator decreases over time. Louise knows all too well the many complications that can be associated with the prolonged use of a breathing machine. In her more than 16 years of practice in medical-surgical, cardio-thoracic and trauma ICUs, Louise, whose expertise is in ventilator weaning, has seen a full

“We believe the time for change has come and the place to begin is with the system we have today.”
From “A Nursing Call to Action” by the Canadian Nurses Association’s National Expert Commission, 2012
cessfully wean from mechanical ventilation faced not only the realization that they would always need to depend on a machine to breathe, but that they were being sent back to the ICU they came from. They did not require ICU care, but there was simply no other place for them to go.

Louise’s research program aims to improve the experience of mechanically ventilated patients across the spectrum of care, from the emergency department to the home. To improve the placements of patients on long-term ventilation (LTV), she joined the LTV Strategy Advisory Group of Toronto Central LHIN (TCLHIN) as the network prepared the “2011 Plan for the Care and Management of Individuals with LTV Needs.” TCLHIN asked West Park Healthcare Centre in Toronto to take a leadership role in developing and implementing a comprehensive plan for individuals with LTV needs. Again, Louise’s research program will help save the health care system money and vastly improve patient care.

WE CAN DO BETTER

In the study, though, Louise Rose and Dr. Fraser describe PWC’s success as just “moderate.” While the results are comparable to weaning centres in other countries, the study reported that only about 50 per cent of patients can completely wean from the breathing machine. This past year, however, the success rate for total weaning rose to 70 per cent. After discharge from PWC, 10 to 15 per cent may need continuing breathing support via a tracheotomy tube or mask during the night and/or part of the day.

The study also reported that 34 per cent of the patients who could not successfully wean from mechanical ventilation faced not only the realization that they would always need to depend on a machine to breathe, but that they were being sent back to the ICU they came from. They did not require ICU care, but there was simply no other place for them to go.

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Four times the honours!

For her doctoral research at U of T Nursing, Krista Keilty is studying the sleep of parents who have a child who requires long-term ventilation (LTV). “I’m looking at what happens at night for a family caregiver of a child with medical complexity who may have a tracheotomy and invasive ventilation or bi-level ventilation, or is oxygen dependent,” she explains. “Their typical sleeping arrangement is not entirely typical.”

This spring, the Canadian and the Ontario Lung Association each awarded Keilty, MN 9T5, a grant and a fellowship to further her research. Keilty’s study will reveal how sleep (or lack of it) affects the caregivers’ health and quality of life, and lead to the development of targeted sleep interventions.

In families with a child on LTV, some parents transform their dining room into the child’s bedroom so there’s enough space for the ventilation equipment and also a cot. At night, a parent will lie on the cot to monitor the child and ensure the breathing equipment is functioning properly. “These families have the opportunity to have a night nurse, but not every night,” explains Keilty.

All ventilation equipment has a built-in alarm to notify the caregivers if there is a malfunction, but the alarm can go off when it shouldn’t and interfere with the parents’ sleep. Sometimes when the alarm should sound, it doesn’t. “Families live with the risk that alarms can fail,” says Keilty. “While the parents sleep, there is the worry that their child could die if the equipment fails.”

She hopes her research will lead to interventions that support families in getting a precious night’s sleep.
GEFFREY FORD, BScN 0T9, is helping to prevent the spread of HIV and improve the lives of people living with HIV/AIDS. Along with other members of the Vancouver STOP HIV/AIDS Outreach Team, Ford is engaging some of the city’s most marginalized populations in testing and treatment, and primary care.

Ford, who is from Vancouver, started as an outreach nurse with the initiative in 2010, just 13 months after graduating from U of T Nursing. In this role, he collaborated with community partners to address the social and environmental determinants of health by helping arrange housing, food and medical care for clients. As well, Ford began to practise at outreach clinics that offer testing for HIV and sexually transmitted infections (STIs).

The clinics specifically address the needs of gay men and other men who have sex with men (OMSM). “Men who have sex with men can’t
POVERTY, HOMELESSNESS, LACK OF SOCIAL SUPPORT, SEXUAL AND PHYSICAL ABUSE, AND LACK OF EDUCATION CONTRIBUTE TO THE SPREAD OF HIV AND OTHER COMMUNICABLE DISEASES.

From “A Nursing Call to Action” by the Canadian Nurses Association’s National Expert Commission, 2012

...be categorized as one homogenous group. An OMSM, for example, doesn’t necessarily self-identify with being gay,” he explains. “He could be a married guy who has sexual activity with men every now and then.”

Then this spring, the agency promoted Ford to nurse educator.

THE BATHHOUSE INITIATIVE

Ford counsels clients on how to reduce HIV risk as part of the bathhouse effort that he helped launch. The initiative expanded outreach nursing clinics into the city’s three major bathhouses. “The bathhouse owners each gave us a room to use as a clinic, which is very generous of them. They don’t have to; a bathhouse is a private business.”

STOP staff turned the rooms into nursing stations that provide the same scope of services and quality of care as any other STI clinic in Vancouver, says Ford. In the bathhouse clinics, the team engages clients in primary care and performs screening tests for HIV, hepatitis, syphilis, gonorrhea and chlamydia. Last year, Ford completed an STI course that certified him to diagnose and treat symptomatic clients with antibiotics on-site.

The initiative reaches men who are not about to walk through the front door of a health clinic and ask for HIV/STI testing. They normally won’t access care for a variety of reasons, ranging from homophobic and stigmatizing past experiences with the health care system, to being afraid of bloodwork. “It’s important to meet clients where they are,” says Ford. “It’s about being present with the right attitude and creating a safe space.”

For some of the clients, trusting a health care professional doesn’t come easily. It can take weeks, if not months, of casual conversations to establish a therapeutic relationship.

“Nurse-client boundaries are a constant conversation topic with our team,” says Ford. “We have clientele who are lonely, who don’t have the level of engagement we provide them. If I recognize that the relationship is becoming too close, I pass the client onto another nurse. Regardless of the environment, nursing practice standards don’t change.”

ESCALATING RISK

At highest risk of HIV infection are men who have multiple anonymous sexual partners and sex in conjunction with illicit drug use. “Crystal meth and alcohol abuse are big concerns in the gay and OMSM community,” says Ford. “Some use drugs and alcohol as a way of getting through life, as a coping mechanism for the trauma, homophobia, abuse and family violence they’ve experienced.

“We see a lot of depression and anxiety disorders that can lead to low self-esteem and risk taking,” he continues. “Addiction combined with mental health issues is the No. 1 challenge to engaging these men in care.”

NO 9 TO 5 JOB

At the bathhouse, Ford works from 11 p.m. to 3 a.m., typically on weekends. And if he diagnoses a man with HIV at 3 a.m., he’ll stay on to help the client begin to come to terms with the diagnosis and to put care plans in place. “Engaging the men in care is the most important piece of our work,” he says.

Care can include highly active antiretroviral therapy (HAART) which suppresses HIV replication and the progression of the disease. It usually includes three or more anti-HIV medications that are sometimes combined in a single daily pill. “Initiating treatment can be a challenge,” says Ford. “During the first month, common side-effects include nausea, diarrhea and sleep interruptions. However, once stabilized on treatment, there are very few, if any, side-effects. While not a cure, HAART helps people who are HIV-positive live very long, healthy lives.” And since it lowers the amount of active HIV virus in body fluids, it dramatically reduces the risk of HIV transmission. It can lower the amount so much that a blood test can’t even detect the virus.

In his new role as nurse educator, Ford has continued to increase HIV services to directly address the needs of gay men and OMSM. This year, he led the expansion of outreach services by co-ordinating the conversion of a van into a mobile HIV testing clinic. The yellow Westfalia with “Know On the Go” on the side made its inaugural stop this August at Vancouver’s Gay Pride celebrations.

Ford admits his nursing role, while enormously fulfilling, takes an emotional toll. “My team is amazing and really supportive,” he says. “I debrief and decompress with my co-workers, which helps a lot. I play beach volleyball with my friends, which also helps keep me sane.”

He says his practice would be easier if HIV wasn’t so steeped in stigma. “I would like to see the attitude that everyone is affected by HIV. Let’s normalize it.”

ManCount, an HIV surveillance study, ranks Vancouver alongside Toronto, New York City and San Francisco in HIV prevalence, with one in five gay men being HIV-positive, and one in 40 of those men not knowing they’ve been infected with HIV.
Among Toronto’s most vulnerable are those who work in the shadows as undocumented migrants
In June, the rotunda in Toronto City Hall was draped with giant paintings created for a research project led by U of T Nursing Associate Professor Denise Gastaldo.

The research team asked 20 undocumented Latin-American workers in the GTA to share their migration journey by making a body map of themselves. “Body mapping allowed the participants to depict their complex transnational lives and let the public relate to the experiences of these non-status workers. Most importantly, this visual research data gave voice and visibility to the workers, who are often invisible in our society,” says Gastaldo, who led the study with Lilian Magalhaes, an occupational therapy professor at Western University in London, Ontario.

Gastaldo and Magalhaes borrowed the idea of body mapping from art therapists in South Africa who use it to help those living with HIV/AIDS. In the approach to body mapping that the Health Consequences of Gendered Economic Migration study took, a facilitator met with each participant individually. After an hour-long interview, the facilitator handed the participant paints, markers and other art materials, and helped the participant depict aspects of his or her migration, working conditions and social participation on a 2.5-by-1-metre canvas. This novel tact provided in-depth information on their social determinants of health.

LEAVING HOME
Each study participant came to Toronto for an important reason. Some came to escape the dangers of political insecurity and drug-related violence. Most came in an effort to support family members back home. The majority entered Canada legally but remained after their visa expired. A few were smuggled in.

Many of the undocumented workers in the study perform what’s labelled 3-D jobs because the work is dirty, dangerous and/or degrading. Three-D jobs are typically out of sight. Undocumented workers peel potatoes in the basement of fish ’n chip restaurants. They wash dishes in the room off the kitchen in upscale eateries. In the dark of the night, they clean toilets in shiny office towers.

Gastaldo explains that while contributing to our economy, Canada’s estimated 500,000 undocumented workers are not protected by citizenship or legal status, and some employers exploit the workers’ vulnerability by paying them less than minimum wage, not following safety requirements and assigning long hours without breaks. The employers keep the upper hand by threatening to report the workers and have them deported if they speak up.

Undocumented workers cannot access preventative and curative health care. They urgently need primary care because their social determinants of health are no less than toxic. “Living in isolation, fear and without social protection has severe health consequences,” says Gastaldo.

HEALTH A SOCIAL EVENT
The National Expert Commission that the Canadian Nurses Association formed in 2011 emphasizes the importance of the social determinants of health. It states that a secure home life, the conditions in workplaces...
What’s your job, anyway?

“To provide care for the sick is fundamental, but it’s no longer sufficient for the largest health care profession in the world,” says Associate Professor Denise Gastaldo, left. She urges RNs to collectively engage in producing health by:

- lending nursing’s professional status to social, political and economic initiatives that diminish the gap between the rich and poor in Canada, and promote social participation;
- challenging managerial norms that interfere with the ability of nurses to care and advocate for vulnerable clients, such as non-insured residents; and
- moving away from blaming individual clients for their health issues and moving toward the recent evidence on the social determinants of health, which takes into account the clients’ subjective and objective social position.

Social position is the best indicator of health,” says Gastaldo, “and immigrants have an acute loss of social position.” She cites research that has shown low social status exposes individuals to a combination of acute and chronic stressors that can weaken the immune system and induce illness. Undocumented workers have the additional stress of living without status. In the study, they reported feeling the need to hide for fear of being exposed to authorities.

International migration also deeply disrupts social support systems, creating isolation, limited social participation and low self-esteem, which can also contribute to acute health conditions and chronic illness. “Most health is produced collectively,” says Gastaldo. “The more equitable the society, the healthier the people.”

For more information on the study, visit www.migrationhealth.ca.

PEPE’S BODY MAP

Pepe was a college student in Mexico when his father died and the family business closed. He determined the only way he could support his mother was by working in Canada and sending money home. Since arriving in Toronto four years ago, Pepe has worked on construction sites and in factories.

To contrast his uncomfortable situation as an undocumented worker, Pepe painted himself in a comfortable fetal position. He wrote “A lot of loneliness” across his forehead to express his isolation. He’s thankful, though, for the support of his friends here and back home, who he represents with handprints on his legs.

He thinks the factory work he has done in Canada aggravated his kidney problems. He coloured red discs and arrows on his spine to represent his radiating back pain. He drew a black stomach and digestive tract, and he attributes some of his health problems to the poor diet he has here.

Pepe knows he should see a doctor but his co-workers have told him that other undocumented workers have been caught when they go to a hospital.

* Pepe is a pseudonym. To provide anonymity to the study participants, the researchers did not know the participants’ real names.
FALLING THROUGH THE CRACKS

Patient information can go astray when clients are transferred to a new facility.
**EVER PLAYED THE TELEPHONE GAME, IN WHICH YOU TELL SOMETHING TO SOMEONE, WHO THEN REPEATS WHAT YOU SAID TO SOMEONE ELSE, WHO THEN REPEATS IT TO SOMEONE ELSE?** asks Lianne Jeffs, BScN 9T2, MSc 9T8, the director of nursing research at and a scientist with the Keenan Research Centre, Li Ka Shing Knowledge Institute at St. Michael’s.

“The more times the information is exchanged, the greater the potential for error.

“By the same token, we need to simplify patient transitions and reduce the number of times information is exchanged,” Jeffs continues. “One way to do this would be for the patient’s nurse at the sending hospital to phone the nurse at the accepting hospital and speak to him or her directly about the patient’s status and plan of care, and flag any pertinent patient issues. Nurses play such an important role in care transitions.”

Jeffs and Jane Merkley, MScN 9T7, Bridgepoint Health’s vice-president of programs, services and professional affairs, recently contributed to a study funded by the Canadian Nurses Foundation that examined ways to improve patient safety in transfers between an acute care hospital and a rehabilitation and complex care facility. “There’s very little known about the safety threats of this transition. We know way more about what constitutes a safe transition home from hospital,” says Merkley. “Our study has shown us some of the gaps in handovers between health care facilities.”

Sometimes the answers to complex questions can be deceptively simple. For example, the lack of a standardized transfer form to record all of the pertinent information and that can be used by all facilities may be unnecessarily complicating patient transitions. “Some transfer forms are only one page, and some don’t even have a place for a nursing summary,” says Jeffs, holding a sample up in the air.

**READY TO GO?**

The study looked at patients who had undergone non-elective orthopaedic surgery; for example, for a hip fracture or complex joint revision. “There are system pressures to quickly funnel these patients out of the acute care hospital and into rehab, but are we discharging them too soon?” asks Jeffs, who is also the associate director of the Nursing Health Services Research Unit at Bloomberg Nursing.

“What we found is that some patients, and family members, feel they are being discharged too early,” she continues. “At three or four days post-operative, they may be medically stable but they don’t feel they can manage going from total care at the acute care site to almost self-care at the rehab and complex continuing care site, where they’re suddenly responsible for their own medications and getting to the bathroom by themselves.”

“Families don’t know what to expect at a rehab hospital,” adds Merkley. “They’re not prepared for the cultural shift that comes with the transition from acute care to an environment that fosters patient self-management and functional independence.”

When a patient from this client population arrives at the rehabilitation facility, he or she may be groggy from pain medication and still reeling from the trauma of the accident that caused the orthopaedic injury. It’s also when the members of the health care team greet the patient and ask a battery of questions about everything from medications to medical history, allergies and rehabilitation goals.

If the patient is frail and/or elderly, the day that he or she is transported to the rehabilitation facility can be particularly trying. “Post-surgical delirium can show up three days after surgery,” says Jeffs, “and a new environment is a trigger for delirium.”

The rehabilitation hospital, though, may be a better setting for a patient with delirium, points out Merkley. The surgical floor in the acute care hospital is a hubbub of activity compared to a rehab facility. “We try to normalize their environment here,” says Merkley, who is also the chief nurse executive at Bridgepoint, which serves individuals with complex, chronic disease.

**THE IMPORTANCE OF FAMILY**

Earlier studies have found that during a transfer, patients and families can identify harmful and potentially harmful events that would otherwise go undetected. “Families play a key role in safe transfers,” says Merkley who, along with Jeffs and the other members of the research team, chose to focus on the perspective of patients and family members during a transfer.

The team identified the need to better engage patients and family members, who reported not knowing what to expect, including the time of the transfer and even the location of the facility the patient was being transferred to. “It’s a systems piece,” explains Jeffs. “Not many of the patients find out where they’re going until the day of the transfer. They’re in a queue.”

The study report, to be published in Patient Preference and Adherence, articulates the need for patients and family members to play a more active role in the transfer. “One of the easiest ways to increase patient safety in a transfer is to engage the patient and the family in transitions planning,” says Jeffs.

Patient safety can also be an issue when patients are transferred within the same facility. Merkley’s team developed an internal transfer checklist, but it’s only part of Bridgepoint’s internal transfer protocol. “A lot can be lost with a checklist,” explains Merkley. “We also arrange for a face-to-face meeting with the sending nurse, the receiving nurse plus the patient, whenever possible. This meeting offers the
opportunity to ask questions and address the subtleties of care. It’s important that the meeting be uninterrupted; nurses tend to get interrupted a lot.”

Safety concerns with internal transfers led Providence Healthcare to eliminate them altogether. “Every time you transition a patient or add new staff to the team caring for a patient, you lose information and there’s potential for error,” explains Maggie Bruneau, BScN 8T1, the executive director of partnerships and chief nurse executive at Providence Healthcare, a Toronto rehabilitation organization. “Patients stay in the same room to which they were first admitted – no moves, no changes. And we’ve implemented improvements that keep the group of staff who interface with a patient consistent and small.”

Creating a Better System
Bruneau helped design Providence’s new model of care, called Transformation by Design. In developing this model, the team used tools that helped them visualize the patient’s journey from an acute care hospital to Providence, and then home with continued recovery through outpatient services.

A particular focus was patients who require rehabilitation after a stroke. “With a stroke, time is muscle,” explains Bruneau. “In the first few weeks after a stroke, there is a window of neuro-plasticity when the brain can make its optimal recovery. We want to get stroke patients into active rehab as soon as possible so we can help them optimize their gains.”

Transformation by Design led to the development of the patient flow co-ordinator role. Providence now has a patient flow co-ordinator at each of its four referring hospitals. Two of these co-ordinators are occupational therapists, and two are RNs. “They’re on-site to collaborate with the acute care teams in pulling patients into rehab in a more timely manner,” explains Bruneau. “The goal is to admit the right patient to the right bed at the right time and to align upcoming beds with patients newly admitted to the acute care hospital. We’re still not as early as we should be, but the new process allows us to smooth the transition.”

The face-to-face meeting with the patient flow co-ordinator, acute care staff, patient and family members allows Providence to prepare the patient and family for what to expect. It also triggers the just-in-time delivery of any equipment—such as an IV pump and wheelchair—that the incoming patient will need. “Previously, this task used a lot of nursing time that is now reinvested in time spent on admission assessments,” says Bruneau. It also gives staff the opportunity to support the patient in the transition by preparing a nutritious snack, and welcoming the patient and family to the new setting.
Over the years, I have seen many documents such as “A Nursing Call to Action,” the recent report of Canada’s National Expert Commission. Indeed, I assisted in drafting two such documents in the U.K. In my work in Central Europe with countries preparing to join the European Union or adjusting to having joined, I have seen dozens more. These documents represent a key moment both clinically and politically in the development of the nursing profession. I have come to a number of conclusions about what these initiatives represent. My understanding runs something like this.

- A number of factors coalesce to develop awareness in the nursing profession that something has to change.
- There is capacity in the profession to win public agreement that something has to change.
- There is political will in the community to examine what has to change.
- A document emerges that states that change is essential.

This formula may appear vague, but with a nebulous profession such as nursing it is often difficult to be specific, at least at the start. The advantages of this vagueness are that it provides the opportunity for wider thinking and prevents rushing to conclusions.

“A Nursing Call to Action” draws on many of the themes that these documents have shared since the Declaration of Alma-Ata, 1978, the first international agreement on the
Our Distinguished Visiting Professor charts how in country after country, it takes nurses to make the difference

importance of primary health care. These themes include an awareness of:
• the impact on health of social factors, especially poverty, but also housing, disability and education;
• the importance of exercise, social activity and health education;
• how helping the most disadvantaged individuals in a community improves health delivery and outcomes for everyone;
• the significance of chronic disease in society and the role of primary care in responding to it; and
• the challenge to acute-care delivery models, which are essentially episodic in nature as compared with continuous care in less acute but more sustainable models.

In this changing and challenging scenario, nurses play a central role. Nurses are the largest part of the trained and educated health care workforce in so many countries. Time and again, nurses have argued their case for change and better models of health care delivery on the basis that it is not what you spend, but how you spend it. Investing in more highly developed nurses goes hand in hand with more patient-centred and devolved models of care.

Perhaps most of all, nurses are perceived as bringing compassion to their work. The word “compassion” always worries me because by applying it to nurses there is the opposite conclusion to be drawn, that perhaps other health care professionals do not show such compassion. I am happier with the notion when I go back to the Latin *cum passio*, one who bears with, suffers with. Nursing, therefore, is part of a process that takes on the suffering of the patient (another word derived from the Latin verb *patior*) as well as brings relief to that suffering. This, of course, lays us open to the criticism that we are emotional and not sufficiently rational in our work. Conversely, it permits nurses to argue the case for the neglected, deprived and marginalized that perhaps others cannot engage with because it makes no economic or social sense to do so; or there could be perceived status or other social factors that mitigate against their involvement.

Nurses are making a difference to the health of nations by working outside of the social and economic box that seems to constrain politicians and, indeed, many of our health care colleagues. If our concern is the care of those who are suffering, it behooves the profession of nursing to quite literally profess their concern for those suffering and to sensitize society to the need to do things differently. This global as well as local challenge is what unites the profession above all else. The practice, social position and pay of nurses vary from country to country; but when nurses come together, their shared dialogue focuses on how to meet the needs of those who are suffering. Compassion built on a foundation of strong education and proper resourcing and shaped by able leadership is demonstrating the ability of nurses to change the experience of ill health worldwide and helping many millions to avoid the diseases that could kill them.

INVESTING IN MORE HIGHLY DEVELOPED NURSES GOES HAND IN HAND WITH MORE PATIENT-CENTRED AND DEVOLVED MODELS OF CARE.

Rev. Tom Keighley, RN, FRCN, is our 2012 Frances Bloomberg International Distinguished Visiting Professor. Keighley, who lives in London, England, represented the U.K. on the European Union Advisory Committee on nursing training for over a decade and continues to facilitate the European Accession Project for the former Eastern Bloc member countries.

At U of T Nursing, Keighley is helping advance our expertise in policy and leadership, and advising on these components in our programs.
**News**

**Spring Reunion**
Alumni came from across Canada, the U.S. and even from Germany to attend U of T Nursing’s Spring Reunion in May. As part of the event, the hundred alumni at the reunion toured our state-of-the-art clinical simulation lab with its lifelike medical mannequins.

Among the honoured guests were those who graduated in a year ending in two or seven. To celebrate their 40th anniversary since graduation, members of the Class of 772 arranged a luncheon in which they showed slides of years gone by. The Class of 677 arranged a reunion lunch to mark their 45th anniversary.

Dean Sioban Nelson extended a special welcome to Peggy Fuller and Madeleine Cadieux, who were celebrating their 70th anniversary since graduating from U of T’s School of Nursing in 1942.

**Our distinguished alumni**
At U of T Nursing’s Spring Reunion, we recognized five graduates who have made exceptional contributions to nursing.

“This is one of my favourite events on the calendar,” remarked Dean Sioban Nelson. “I love the opportunity to recognize the enormous contributions of these alumni to health care and to their communities.”

The honoured recipients—who had been nominated by their peers and then selected by committee—each received a Distinguished Alumni Award.

**Agnes Gelb**, BScN 575, received the Class of 1955 Award for her service as the director of the home care program for the Wellington-Dufferin-Guelph area. In this role, she helped develop home care for palliative care patients.

**Laura Hanson**, MN 170, received the Rising Star – Community Nursing Award for her work with marginalized populations, and for promoting social justice by addressing issues related to poverty, homelessness, addiction, mental illness and sexual health.

**June Kikuchi**, BScN 672, established the Institute for Philosophical Nursing Research at the University of Alberta with her colleague, Helen Simmons.

**Helen Kirkpatrick**, BScN 774, MScN 875, practised in the Schizophrenia Psychosocial Rehabilitation Program at Hamilton Psychiatric Hospital. She led the establishment of a community-based housing project to meet the goals of patients who are severely disabled by schizophrenia.

**Katherine Williams**, Certificate in Public Health Nursing 572, devoted her nursing career to the health and well-being of the people of Guysborough, Nova Scotia. She was a founding member of Guysborough Memorial Hospital, and started the Well Men’s and Well Women’s clinics. After recognizing the issue of food insecurity in the community, she helped initiate a food bank.
Breakfast with the Dean
At a breakfast in early October, Dean Sioban Nelson greeted some of the more than 170 students starting the Bachelor of Science in Nursing program at U of T Nursing. Our two-year undergraduate nursing program is designed for individuals who already have at least 10 university credits. Entry into the program, though, is highly competitive.

Almost all of this year’s entry-level students have an undergraduate degree, and some have a graduate degree as well. With so much education already behind them, today’s first-year nursing students may be older than you were when you started U of T Nursing. The average age of a first-year BScN student this fall is 25.

“This maturity places our BScN students on a par with the other health science students at the university,” says Nelson, “and I believe it is one of the reasons why we have been so successful in our interprofessional education initiatives. It’s difficult to make a team with learners who are school-leavers and others who are in their mid to late 20s and have one or two degrees under their belt.”

Top-of-the-Class Teachers
Every fall, U of T Nursing acknowledges some of its exemplary professors with a teaching award. Among the 13 teachers recognized this year are Tracey DasGupta and Sherri Adams, who each won an Excellence in Preceptor Graduate Award.

DasGupta, the director of nursing practice and informatics at Sunnybrook Health Sciences Centre, taught by example. She role modelled passionate care and a commitment to excellence, inspiring our master’s students to go the extra mile. Adams, an NP at the Hospital for Sick Children, has been a preceptor since 2008; her students praise her for giving them ample time, offering constructive feedback and encouraging their efforts.

Jim Smith, a preceptor at Princess Margaret Hospital, received the Senior-Year Excellence in Clinical Teaching Award. Smith’s students reported that he modelled exemplary care by taking the time to get to know all of his patients and to receive feedback from them as well. He also modelled self-care by insisting that students accompany him for “wee tea breaks.”

Hodnett wins CNA Research Award
In June, the Canadian Nurses Association honoured Professor Ellen Hodnett with its Order of Merit Award in Nursing Research. The award acknowledges Hodnett’s significant and sustained impact on the nursing profession and the practice of nursing in Canada.

Hodnett’s research program focuses on rigorous evaluations of forms of care for childbearing women. It also examines how the physical setting for labour affects the behaviour of women and their care providers, as well as birth outcomes.

At U of T Nursing, Hodnett, MScN 8To, PhD 8T3, was the driving force behind the development of our Randomized Controlled Trials Group. The Group assists colleagues and graduate students in designing and conducting trials of simple and complex nursing interventions.

Howell wins Oncology Award
This spring, Professor Doris Howell, MScN 8T3, received the Canadian Association of Psychosocial Oncology Award for Education Excellence.

To improve the cancer patient’s experience, Howell focuses on developing and testing strategies to educate patients in self-management interventions for symptoms such as breathlessness, pain and fatigue. “I want to be sure that individuals with cancer receive the highest quality of care to reduce the burden of living with this disease,” she says.

At U of T Nursing, Howell developed the Clinical Nursing Stream – Oncology curriculum in the master’s program.
Identical twins Charmaine Caron and Charlotte Coulombe both graduated from U of T Nursing in 1962. They had the same childhood and earned the same nursing degree, but their lives turned out to be far from identical. Life is full of surprises, as alum Brenda Tiffan discovered when she found herself in Malawi.

25 YEARS OUT: Brenda Tiffan, BScN 8T7, most recently worked part-time as a school nurse in the Hilliard City School District in Ohio, managing clinics mainly in the middle and high schools. With training from the Ohio Department of Health, a key part of her role became hearing and vision screenings. Previously, Tiffan worked as a staff nurse at Akron Children’s Hospital and conducted nurse education in several other settings.

Most exciting to Tiffan is her recent involvement with the Passion Center for Children in Zomba, Malawi. She has joined the Center’s medical board as a project manager, a role that involves supervising vision clinics.

After training with David Curtis, an optometrist who has pioneered vision care in resource-constrained countries, Tiffan visited Malawi in 2011 to run vision clinics in village and rural settings as well as at the Passion Center for Children. In Malawi, Tiffan trained a team to assist with eyeglass fittings and administer eye medications. With the help of local translators and other volunteers from the States, Tiffan helped treat more than 500 patients that first summer. In addition, she educated a pastor at the Passion Center to run vision clinics throughout the year.

This past summer, Tiffan returned to Zomba to provide additional training to local staff and offer clinics in more rural village settings. And once again, she brought her daughter, Kara, who is training to be a nurse.

“Access to eye care in Malawi is sadly lacking,” says Tiffan. “The work is challenging, but providing simple prescriptive lenses or medications can monumentally affect a child’s opportunity to enjoy success in school or an adult’s ability to continue in a job and provide for his or her family.”

50 YEARS OUT: Charmaine Caron, BScN 6T2, MScN 8T4, has practised in three domains of nursing: clinical, education and administration.

Her experience has been wide and varied, beginning her career as a staff nurse with the Victorian Order of Nurses and retiring nearly 40 years later as vice-president patient care at the Salvation Army Scarborough Grace Hospital. Through the years, she assumed clinical educator roles and held progressively senior nursing administrator positions at both teaching and community hospitals in Toronto.

As a nurse administrator, Caron worked hard to share the knowledge she had gained through experience by speaking at numerous conferences and participating on various committees and task forces throughout the GTA.

Since retiring, Caron has focused much of her attention on quality improvement and measuring outcomes, accepting contract health care consultant positions and actively serving for six years on the board and committees of the Salvation Army Meighen Health Care Centre, a Toronto long-term-care and senior residence facility.

50 YEARS OUT: Charmaine’s identical twin Charlotte Coulombe, BScN 6T2, married in her final year at U of T Nursing and a year later gave birth to their first son. Two more sons followed in quick succession. But a houseful of little boys couldn’t keep Coulombe from nursing. She did what every creative mother does and made the most of what little free time she could find.

For example, when her second son was six months old, she started to work part-time on the surgical unit at Peel Memorial Hospital in Brampton, Ontario. She chose the evening shift, so her husband could care for the boys.

Then when her third son went off to elementary school, she worked part-time days as an instructor at Sheridan College, teaching in the home support program.

Later, Coulombe volunteered with a variety of health agencies, including the Canadian Cancer Society, the Canadian Red Cross, St. Elizabeth and the Peel Region Health Department. In 1992, she was awarded a Canada Commemorative Medal for her significant volunteer contributions to the community.
A CONVERSATION WITH DR. ARLENE BIERMAN

The principal investigator of the POWER study and Bloomberg Nursing associate professor shares her insights on health inequity among the elderly

**Pulse:** What causes health inequity among our seniors?

**Bierman:** As we grow older, our health is the product of our experiences over our life course. Low-income Ontarians and older women in particular have a much higher burden of chronic disease and disability than their more affluent counterparts.

In the Project for an Ontario Women’s Health Evidence-Based Report (POWER), we found large and modifiable inequities in health and functional status among older adults. These health inequities are much greater than the inequities in access to and quality of care. This finding highlights the need to address the social determinants of health to reduce and ultimately eliminate health inequities among our elders.

**Pulse:** Are we ready to meet the needs of our aging population?

**Bierman:** No, Ontario has underinvested in disease prevention, leading to a growing burden of chronic disease. Because our health care system was developed to care for acute illnesses, it often falls short on chronic illness care.

Many older adults have complex social needs and multiple conditions, but care delivery and quality improvement efforts often focus on single diseases, such as heart failure or diabetes. Consequently, seniors tend to see multiple providers in multiple care settings, such as ambulatory primary and specialty care, hospital care and home care. Their health care is often fragmented and poorly integrated with community services.

Compounding the problem is that the workforce lacks geriatric competencies. Ontario’s increased focus on quality improvement and its work on a senior strategy can help us get ready.

**Pulse:** How can we re-engineer the system?

**Bierman:** Primary care is central. There are local pockets of innovation across Ontario that are implementing effective strategies to improve elder care, and internationally there is growing evidence for effective models. We need to learn from and widely implement these innovations.

Briefly, we need to increase our focus on chronic disease prevention and management. We need to integrate care across the health care system, and we need to integrate and co-ordinate social and community services with health care delivery. Co-ordinating population health, public health and health system efforts will help accelerate our progress.

Performance measurement and monitoring are essential to health system transformation. POWER illustrates why gender and equity analysis of quality indicators needs to be routine. We identified a leading set of health equity indicators that can inform improvement efforts and serve to monitor progress to ensure we are achieving the goal of improving health and well-being while reducing inequities.

**Pulse:** Name one thing a nurse can do today to improve the care of older adults.

**Bierman:** Listen. By listening to our patients we can better understand and meet their needs while gaining insights into how to transform health care to be more patient-centred.

Echo’s Ontario Women’s Health Council Chair in Women’s Health, Dr. Arlene Bierman is a U of T Nursing associate professor, a general internist and a geriatrician. She was the principal investigator of the Project for an Ontario Women’s Health Evidence-Based Report (POWER), www.powerstudy.ca, which involved more than 60 researchers. Bierman is a founding member and board member of the National Initiative for the Care of the Elderly (NICE). This international network of researchers, practitioners and students is dedicated to improving the care of older adults. At the Faculty of Nursing, she supervises doctoral students and is a popular teacher of research design and critical appraisal of health literature.
Time Travel

Professor George Beaton from U of T’s Department of Nutritional Sciences and Dr. Richter of Guatemala discuss food initiatives in Central America with Brenda St. Hill, a U of T Nursing student. St. Hill graduated in 1963 with a Certificate in Public Health Nursing.
"Nursing in Canada has a history of excluding women of colour," said Karen Flynn at Bloomberg Nursing’s launch of her book *Moving Beyond Borders: A history of black Canadian and Caribbean women in the diaspora*.

The June event celebrated the black nurses who were born in Canada or who came to Canada after the Second World War. Many of these women had to confront the patriarchal authority of white, male physicians to practise nursing in this country. The launch also acknowledged the contributions of the black women who graduated from Ontario nursing schools at a time when, all too often, skin colour was linked to intelligence. “These nurses were pioneers,” says Flynn. “They led the way to integrate black women into nursing schools and hospitals.”

In Canada, black women weren’t allowed to train to be nurses until the late 1940s. U of T Nursing, though, accepted black nurses from other countries for its public health and education programs as early as 1937. These nurses, who came to U of T on a Rockefeller Foundation scholarship, didn’t stay in Canada. After graduating, they returned to their homelands to assume nurse leadership positions.

When University of Toronto Press published *Moving Beyond Borders* last year, the publication became the first book-length history of black health-care workers in Canada. “My book is unique in that it looks at women’s lives as migrants, wives, mothers, single women and in other roles,” says Flynn, an assistant professor in African, gender and women’s studies at the University of Illinois.

The book sits you on the living-room couch in each of the nurses’ family homes. Then it introduces you to the nurse’s parents and proceeds to show you pivotal scenes from the nurse’s childhood. This novel approach to recounting history reveals how the interplay of race, gender, socio-economic status, religion, migration and education shaped the women who took on pioneering roles as nurses and community activists in Canada.

To research the book, Flynn interviewed 35 black nurses from the postwar era, including three U of T Nursing alumni. Among them was Daphne Bailey from Jamaica. Bailey migrated to Canada in 1960 after training to be a nurse and midwife in Britain. In England, Bailey was the only black person in her class, and it wasn’t long before a classmate hurled a racist insult at her. “I put her in her place, and we got along fine after that,” she recalls. “We became good friends.”

When Bailey first arrived in Ontario, she practised in the intensive-care unit at Brantford General Hospital. Her friends, though, urged her to further her education. “If you don’t do anything, you’ll stagnate,” warned one. At the time, U of T Nursing offered a one-year program in public health nursing, and being a public health nurse had been Bailey’s childhood dream. Back in Middlesex County, where Bailey was raised, the public health nurse was held in high esteem, and a chauffeur drove her from patient to patient. “As far back as I can remember, I wanted to be a public health nurse,” she says.

At U of T Nursing, Bailey can’t recall a single incident of racism. After graduating in 1971, she practised with VON for 22.5 years. While continuing to upgrade her education, she provided home care for patients “from the cradle to the grave.” And while she didn’t have a chauffeur to drive her, Bailey did have a caseload of clients who looked forward to her every visit.

In *Moving Beyond Borders*, Flynn reports that some black nurses suffered racism from their patients. One nurse recounted that her patients “didn’t want any black hands to touch them.” Bailey, though, says all of her patients loved her. “I got along fine. Life is what you make it.”

“There is no monolithic black nurse experience,” writes Flynn. And this idea is demonstrated in Lillie Johnson’s very different experiences both at U of T Nursing and in the community.
Johnson migrated from Jamaica to Scotland to study nursing and midwifery. Soon after moving to Toronto in 1960, she enrolled in U of T Nursing’s public health program. Johnson notes that while there were a few other black nurses in her class, there were none on staff. “I kept looking for black faces in the alumni magazine, but the people in the photographs didn’t look like me,” she says. “Nursing needs to pull up its britches and end this sad story.”

After attending U of T Nursing to earn a Certificate in Public Health Nursing in 1962 and a BScN in 1969, Johnson was eager to enter our master’s program. She applied but says prejudicial marking slammed the door on this opportunity.

Gaining employment was also fraught with racism for Johnson who remembers job application forms that asked for your eye colour and skin colour. “Once they found out you were black, that was it,” she says.

When Johnson did get hired, again she faced racism. While practising at the Hospital for Sick Children, for example, a white nurse would befriend her on the bus and then act as if she didn’t exist when they arrived at work. “It was very lonesome working at Sick Kids,” she says. When she switched to home care, clients would phone the office and ask the agency not to send a black nurse next time.

“You need to press on,” says Johnson. “It was a fight, but if you know your job you can stand up to any challenge.”

Johnson more than stood up. She soared! Her success as a public health nurse working with new mothers and young children led to her becoming Canada’s first black director of public health. Supervising a staff of 100, including 50 nurses, in the Leeds, Grenville and Lanark District Health Unit in eastern Ontario, Johnson went on to hire the agency’s first male nurse. “The other nurses gave him a hard time. They ostracized him,” she recalls. “You have to break through barriers, and the gender barrier has got to stop.”

There was certainly no stopping Johnson. After retiring, she founded the Sickle Cell Association of Ontario and contributed to the Ontario Ministry of Health and Long-Term Care’s decision to screen for the disease in newborns. In 2011, Bloomberg Nursing honoured her outstanding contributions with a Distinguished Alumni Award.

“There are so many lessons you can learn from these women,” says Flynn. “You just need to listen.”

Both Lillie Johnson (left) and Daphne Bailey (below, front row) started their nursing career in the U.K.
Events

**Fall Convocation Reception**
Prior to convocation, Bloomberg Nursing will host a function for its 2012 BScN graduates. Each grad may invite two guests to the reception, which will be held in the Music Room at Hart House from 2 to 4:30 p.m.

To RSVP: Email development.nursing@utoronto.ca or phone 416.946.7097.

**Alumni Lifelong Learning Lecture**
Exclusive to U of T Nursing alumni, the luncheon lecture series highlights the latest research of our esteemed faculty members. This lecture features Assistant Professor Robyn Stremler who’ll discuss her research on improving sleep for pregnant women, and determining if sleep problems during pregnancy increase the likelihood of health problems for the mother or baby. The event begins at noon and is at the U of T Nursing building at 155 College St. Lunch is included.

To LEARN MORE: Contact the Alumni Relations Office at development.nursing@utoronto.ca or 416.946.7097. Or, visit www.bloomberg.nursing.utoronto.ca

**Course: Pain Institute**
This three-day program led by Jennifer Stinson, an assistant professor (status), will focus on pain as a prevalent, universal symptom that can have a major impact on individuals, their families and society. It will discuss specific pain assessment and management practices and related diagnostic reasoning and management based on theoretical models and research. The institute, presented by the Centre for Professional Development, is tailored to the learning needs of advanced practice nurses and NPs practising in pain management and/or anaesthesia roles.

To LEARN MORE AND REGISTER: www.bloomberg.nursing.utoronto.ca

**Course: Preparing to Write the NP–Adult Exam**
Learn from NPs who have successfully written the American Nurses Credentialing Center (ANCC) exam for adult health care. The Centre for Professional Development designed this two-day course to help you enhance content knowledge and develop approaches to answering multiple-choice questions.

To LEARN MORE AND REGISTER: www.bloomberg.nursing.utoronto.ca

**Course: Preparing to Write the NP–Paediatric Exam**
Gain confidence in writing ANCC’s exam for paediatric NPs. Taught by NPs who have successfully written the exam, this Centre for Professional Development course will help you enhance your content knowledge, develop approaches to answering multiple-choice questions and identify areas of weakness that need further study.

To LEARN MORE AND REGISTER: www.bloomberg.nursing.utoronto.ca

**Course: Preparing to Write the CRNE**
In this two-day Canadian Registered Nurse Exam (CRNE) preparation course, you will review the exam structure and study approaches to answering multiple-choice questions. You will also 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 Centre for Professional Development course is offered in Toronto; Thunder Bay, Ontario; and Alberta.

To LEARN MORE AND REGISTER: www.bloomberg.nursing.utoronto.ca

**Course: The Foundations and Scholarship of Clinical Teaching**
The complexity of the clinical environments in which nursing education takes place creates unique challenges for both novice and seasoned clinical teachers. In this U of T Nursing Centre for Professional Development course, the faculty members will highlight the scholarship and the art that support successful, creative clinical teaching.

To LEARN MORE AND REGISTER: www.bloomberg.nursing.utoronto.ca

**Course: National Institute on Nursing Informatics**
Assistant Professor Lynn Nagle will lead this Centre for Professional Development program that will provide a broad introductory curriculum on the use of information technology to support clinical patient care, as well as the management, delivery and evaluation of health care services. An international faculty will facilitate didactic, group and self-study learning opportunities. To ensure a focused experience, registration is limited.

To LEARN MORE AND REGISTER: www.bloomberg.nursing.utoronto.ca
U of T Nursing offers innovative educational opportunities for nurses and other health care professionals through its Centre for Professional Development. Enrolment is limited to ensure a high-quality experience, so register early for a program to expand your knowledge in clinical practice, education, leadership, research or informatics.

**Upcoming Courses**

The Foundations and Scholarship of Clinical Teaching  
Dec 11 and 12

Pain Institute  
Winter 2013

National Institute on Nursing Informatics  
Feb 22 to 24

NP-Adult Exam Preparation Course  
April 12 and 13

NP-Paediatric Exam Preparation Course  
April 12 and 13

CRNE Preparation Course  
April/May 2013

For information on upcoming programs, refer to Events on page 29 or visit www.bloomberg.nursing.utoronto.ca