I ACHIEVED MY DREAM
BUT I COULDN’T HAVE DONE IT WITHOUT YOU

PHILIZ GOH, BScN '10

When you include U of T’s Faculty of Nursing in your will, you’re helping students such as Philiz Goh. With the support of student scholarships, Philiz graduated on the Dean’s Honour Roll and fulfilled her dream of becoming an RN.

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New Views on the Old

Congratulations to all those involved in the latest edition of Pulse. I have looked at every page with great interest and read several articles that pertain to people I know, such as Judith Young, Sioban Nelson and Gail Donner. I know I am going to enjoy the information (much of which looks new to me) about Kathleen Russell.

Glennis Zilm
Member, B.C. History of Nursing Society

Fond Memories

The story about Miss Wilson (you call her Jean, but we students certainly did not) was a terrific reminder of what a great teacher she was. Missing, however, were two of her famous sayings: "Nothing on the floor but your feet" and "Observation is the faculty of taking notice." Good advice for any nurse anywhere--or for anyone, when you think of it.

A person not recognized in this issue is Dr. Upritchard. Not a nurse, she taught a course called "The History and Philosophy of Nursing." When I saw that on the course list for fourth year, I thought it would be boring. In fact, it was one of the most important and interesting courses we had.

For example, who knew, until she told us, that Florence Nightingale spent the last 50 years of her life thinking she was near death? We learned about the importance of the Weir Report, which you describe, and the Hall Commission Report, which encouraged nursing to advance to where we are today.

I retired from nursing many years ago, but I remember my four years at U of T as being some of the most important in my development.

Margaret Kenzie Lounds, BScN 6T5

Two Nurses Mistaken for One

In the last issue of Pulse, I have one comment concerning the “Notable 90” section. In the 1930s, there is an entry for Eileen (Ethel) Cryderman. Actually, Eileen and Ethel Cryderman are two different people--sisters who were both notable in the public health field.

Eileen was the director of public health nursing for the City of Toronto’s Department of Public Health in the 1950s and ’60s. In the same time period, her sister Ethel was the director of the Toronto VON, as mentioned in your entry. Each sister made outstanding contributions to the development of public health nursing in Toronto.

Thanks for your review of U of T’s nursing history. Having been in the first class to begin their studies at 50 St. George St., I especially enjoyed the pictures and descriptions of the School of Nursing at 7 Queen’s Park Cres. Here’s to the next 90 years!

Betsy (Stein) Schubert, BScN 5T7
Le Lignon, Switzerland

Editor’s note:
Our apologies to the Cryderman sisters, Eileen and Ethel. Thank you both for your outstanding contributions to public health nursing!

Tell Us What You Think!

Do you have an opinion or question about an article in this issue of Pulse? Drop us a line at pulse.magazine@utoronto.ca or the Bloomberg Faculty of Nursing at:
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Published letters may be edited for length and clarity.
Imagine a hospital or health service without infection control processes, without care coordinators or discharge planning procedures, without patient safety audits, without orientation sessions or nurse educators. Sadly, depending on where you live and your most recent interface with the health care system, you may find this exercise requires little imagination. But despite the uneven distribution of nurses across the country, one thing is certain—nurses are at the forefront of major innovations in health care. Nurses put the “system” in the health care system.

Without nurses connecting the dots and navigating people (both as individuals and as populations) through their health care journeys, all we would have are points of care in an unaligned set of services. And on this point everyone agrees—uncoordinated care is expensive and the outcomes are poor.

We seldom look beyond vital frontline care to notice the multiple, critical roles nurses play in creating a sustainable health care system. In this issue of Pulse, we focus on this blind spot and salute what nurses do away from public view to ensure care is timely, safe and effective. This is what management and leadership roles do; quite simply, they make the system work.

Nurses know what happens when these roles are cut and, unfortunately, these cuts are made with every budget squeeze. Cutting advanced practice and leadership roles is a surefire way to debilitate the system, increase pressure on frontline nurses, damage the capacity to provide safe care, and completely wipe out the health promotion and disease prevention initiatives that prevent the system from collapsing under its own weight. There are no savings to be had in cutting nurses. Indeed, balancing the books in the short term only passes the costs onto other parts of the system—to caregivers who become ill themselves, to home care or long-term care facilities that become unable to cope, and to overcrowded emergency rooms.

Health care professionals, politicians and policy-makers understand the problems: we know unhealthy lifestyles lead to chronic disease, and we know hospitals are very dangerous places, particularly for those who are older or suffer from one or more chronic diseases. What we don’t know is the best way forward, how best to tackle these issues and create a sustainable framework for a health care system that not only meets these challenges but effectively supports disease prevention and promotes health.

These are the very issues our next generation of nurse leaders is taking on. Students in the administrative stream of our master’s program come to grips with system issues by examining everything from patient safety to staffing to health policy. In the MN/MHSc program, our students abound with new ways of thinking and working, and are being groomed for executive roles. In the health services field of our doctoral program, student research is breaking new ground in key areas, from emotional intelligence to workplace violence.

This issue of Pulse also brings you some of the amazing scholarship our faculty members are leading. Their research examines key questions such as, Why are Canadian nurses still going south, and are they coming back? Other research probes the uncharted territory of patient safety in the home and community sector. Finally, and perhaps most importantly, read about the extraordinary contributions our alumni have made toward creating a safe, sustainable health care system.

It’s a great story and an important one: nurses make the system work!

Dean’s Message

NURSES WORKING BEHIND THE SCENES HAVE PUT THE “SYSTEM” IN THE HEALTH CARE SYSTEM.

NURSING’S LEAST UNDERSTOOD ROLES

Sioban Nelson, RN, PhD, FCAHS
When broaching the question of leadership in nursing, it is difficult to know where to begin. At every turn there are textbooks, papers and journals devoted to nursing leadership. They describe everything from clinical leadership to professional leadership. Leadership programs offer nurses management training, political and policy training, and emotional and spiritual self-development, to name but a few. They target everyone engaged in nursing—from students in practical nursing programs to senior executives in major health care organizations. Suddenly, it appears, the lack of nursing leadership has been diagnosed as the major problem for the profession, and the whole world is working to turn each and every nurse into the leader he or she needs to be.

One problem with buzz words—such as “leadership”—is that they are parasitic. American president Theodore Roosevelt coined the term “weasel words” to describe these buzz words that colonize and then suck the meaning out of other words. Weasel words take over other terms, making them sound outdated; but as a buzz word grows in influence, paradoxically it loses meaning. A good illustration of this phenomenon is the rather irritating way that every salesperson is now a consultant. And somehow over the course of the 1980s, passengers and patients became customers and clients. Has the era of business-speak led to a radical improvement in the quality of services across the board? Hardly!

Perhaps we should examine our vernacular to identify what issues nurses need to address today.

The term “leadership in nursing” is also at serious risk of losing its meaning and power. Sometimes when we talk about nursing leaders what we are really talking about are competent practitioners, effective managers, innovative clinicians, resourceful advocates or humane professionals. In a world in which nurses frequently express concern that the public doesn’t understand what they do, it seems folly to collapse all of these attributes into the bottomless leadership bucket. One might wonder what the concept of leadership even adds to the discussion.

It wasn’t always this way

In the past, the hierarchical institutional structures and top-down leadership styles of the typical health care organization suppressed rather than supported its staff. An older colleague tells of her application to a prestigious nursing program in London, England, during the 1950s. During the interview, she was asked about her father’s employment. When she replied that her father was deceased, the nursing superintendent said coolly, “I didn’t ask you where he was, my dear, but what he did.” As late as the mid-’70s, one colleague bitterly recalls her first day as a nurse in a large hospital in Australia where the chief nurse “welcomed” the assembled new staff with the admonition: “No one has asked you to come. If you don’t like it, you are free to leave.” I recall a small regional hospital where I worked (in 1990!) that was so bureaucratic that new staff members were expected to provide dental X-rays for the HR files. Apparently this was for identification purposes should we perish in a fire while on duty.

In these kinds of organizational cultures, leadership was defined by one thing only—where you ranked on the totem pole. Everyone from students to senior staff knew who was in charge of whom, and the organizational shape was a pyramid, with many foot soldiers and few officers. Instructions could not be questioned and initiative was synonymous with insubordination.

U of T always produced leaders

The leadership and knowledge required to transform the practice environment from such rigid origins grew through partnerships between the service sector and academia. U of T’s nursing school provided management training as a certificate program as early as the 1920s. We educated experienced nurses in the skills they needed to lead organizations, and we developed new programs, such...
as the one in public health nursing. The grads of that program went on to develop public health services both in Ontario and across the country.

At one stage, our nursing graduates completed a five-year program that included basic nursing, management and public health. A good many of these highly educated nurses moved into major leadership roles in education, management and the community. New roles burgeoned for nurses with the postwar social welfare agenda as Canada struggled to meet the service needs of its growing population, and it was often U of T graduates who provided leadership in new communities across the country. With limited resources, our nursing graduates led initiatives to face new problems in a highly political environment.

These nursing pioneers would likely not identify with much of the contemporary discourse on nursing leadership. Often, these strong individuals were from an elite background and shaped by a set of values that saw leadership as one of the duties of privilege. Nursing leaders such as Agnes Snively, Kathleen Russell and Lyle Creelman were women of their time, and Canada was fortunate to have had their leadership on both the national and international stage.

The democratization of the concept of leadership that revolutionized organizational culture in the second half of the 20th century was premised on the logic that engaged employees who are enthusiastic about the company’s mission are both more productive and more effective. Management science, organizational psychology and the rise of business schools provided the knowledge and impetus to institutions, industry and government to overhaul their work practices and to begin to think about human capital as a valuable, as opposed to disposable, resource. In health care, this evolution in organizational thinking represented a seismic shift—nurses had to be supported to do their work well for the benefit of the system.

NURSE LEADERS NEEDED
How far have we come from the days when most nurses were simply expected to do as they were told without question and could ‘leave if they didn’t like it’? There is no doubt that much has been accomplished. Nurses today carry enormous responsibilities from direct practice to organizational oversight in ensuring the health care system is safe and effective. Increasingly, frontline nurses are degree prepared and more knowledgeable, articulate and theoretically informed than their predecessors. Advanced practice nurses have supported and led the proliferation of complex programs of care across inpatient, ambulatory and home care settings. Effective organizations fulfil their quality and accountability mandates through the utilization of nursing expertise in patient safety, infection control, program management, mentorship and peer education.

Despite these gains there remains much to do. Twenty or 30 years on from the revolution in organizational thinking that hit health care, we are still grappling with the partial and uneven transformation of the organization of nursing work. The shortages of all kinds of nurses—novice, experienced, faculty, managers and leaders—continues today. Hiring practices are still not recession proof, despite the proven cost to the system that comes from staffing cuts and the subsequent staff shortages that limit the system’s ability to meet demand in the long term. Nursing education remains significantly underfunded compared to other professional programs. And supported transition-to-practice programs for new graduates are not built into our health system budgets as they are in other professions and for nurses in other countries.

So what is the problem to which leadership is the answer today? If the answer is everything, perhaps we need to expand our vocabulary to better articulate the problems we need to address. After all, a sure test of leadership is the ability to name the problems—that step is a necessary prelude to confronting them.
Our master’s graduates are driving innovation in practice, policy and system delivery.

The LEADERSHIP Engine

As you can see from these photos, the former classmates who got together at an event in March had a lot of fun reuniting, sharing stories and meeting faculty and staff. As the evening progressed, one point became crystal clear: our master’s grads are behind every major nursing initiative in the province.

Take the launch of Health Outcomes for Better Information and Care (HOBIC) in Ontario, for example. During its creation, the executive lead was Dorothy Pringle, one of our former deans. And Pringle’s team was composed of two U of T master’s grads—the project manager was Peggy White, MN 9T9, and the information technology lead was Lynn Nagle, MScN 8T8.

Since the Faculty of Nursing first introduced its master’s program in 1970, hundreds of nurses have graduated and gone on to excel in leadership positions in hospitals, and policy development at the local, provincial and national levels. They’ve courageously furthered nursing by pioneering everything from the role of the nurse practitioner to state-of-the-art informatics to facilitate decision-making.
Today, our two-year master's program has three separate fields: clinical nursing, nurse practitioner and nursing administration. Nagle is a lead professor in the administration stream, and in this field students learn how to make health care organizations hum. They learn how to measure nursing care effectiveness; how to design, appraise and utilize research; and how to harness the synergy that arises when health care professionals come together to help others.

**JOYFUL GRATITUDE**

"My undergrad and master's shaped who I am," says Joy Richards, BScN 8T1, MN 0T0. "In the master's program, especially, I was stretched and challenged. The program nourished my soul."

Richards is one of the pre-eminent nurse leaders in Canada. She is the vice-president, professional affairs and chief nurse executive at University Health Network in Toronto. As the Network's most senior nursing leader, Richards oversees more than 3,500 clinical nurses.

She's grateful to two of our former deans—Dot Pringle and Gail Donner—as well as our current dean, Sioban Nelson, for their lessons in leadership. "They taught me to have the courage to speak the unspeakable. They taught me that to do anything, you have to dare to fail," she says. Intrigued with these and other nurse leaders, Richards focused on the development and practice of feminine courage in leadership for the doctorate she earned at Fielding Graduate University in Santa Barbara, California.

"My own leadership philosophy is to listen with really big ears," says Richards. "The staff must be nurtured; they must be encouraged to challenge the things around them that aren’t right. I try to create space for nurses at all levels of the organization to be the best they can be."

In an organization as mammoth as University Health Network, there are a multitude of variables to consider when proposing any change, and those variables constantly shift. Richards credits Bloomberg senior lecturer Francine Wynn for helping her understand the complexities and interconnectedness of health care environments, starting in her undergraduate program. "Francine helped me feel comfortable in the soup of ambiguity," says Richards.

"When I started the master's program, I didn’t know what I didn’t know," she continues. "Now when I’m faced with a challenge, I reach down to what I learned in my master’s to pull myself up."

**THE TRAILBLAZER**

"I like trying new things," says Lianne Jeffs, BScN 9T2, MSc 9T8. Many of Jeffs’s roles have been new positions created to move new platforms forward. Her current role is no exception. Jeffs is director, nursing research and a scientist with the Keenan Research Centre, Li Ka Shing Knowledge Institute at St. Michael's. Her focus is professional nursing practice, quality improvement and patient safety. "Nurses have a moral and ethical obligation to produce knowledge that addresses key safety issues," says Jeffs, who is also a Bloomberg professor (status). "Leadership to me means enabling nurses to optimize their potential as knowledge workers to advance excellence in health care."

In 2008, she designed the Nursing Research Advancing Practice (RAP) program with partners from St. Mike’s and academic institutions, including U of T. It offers nurses the opportunity to participate in a learning strategy with a research mentor; together, they transform a clinical question in their practice area into a research study.

One team investigated how to quench the thirst they noticed many of their hemodialysis patients suffered because they need to limit their fluid intake between dialysis treatments. To alleviate this uncomfortable sensation, the nurses launched the “Sugarless Candy Study” to evaluate if sucking on sugarless candy decreases the perception of thirst.

"Some of the nurses found the research process took them out of their comfort zone," reports Jeffs, who received an IHSPR Rising Star Award for the RAP program. "They likened the RAP experience to ‘riding the wave’ or a roller-coaster ride, but their mentors helped them demystify the research process." Other nurses became so intrigued with research they enrolled in graduate studies to further their investigation skills.

"U of T primed me for leading the RAP experience," says Jeffs. "In the master’s program, I learned the importance of advancing scientific knowledge through partnerships, networks and context. I learned what I needed to know to make RAP work."

**THE E-CONNECTION**

Barb Duffey-Rosenstein, MScN 9T3, is one of the first graduates of our master’s administration stream. Her inter-
the need to continue to learn and adapt in an ever changing nursing strategic plan,” she says. “This research led to a very strong environment in which nurses feel supported to be their best. “Mobile health is so exciting,” she says, “and nurses play a significant role in it.”

Duffey-Rosenstein says becoming a leader has been an organic process that has evolved over time. “Throughout my career, I’ve had a succession of opportunities to develop my leadership qualities and abilities,” she says. “Without question, gaining advanced knowledge through U of T’s master’s program has led to a lot of opportunities for mentoring, support and exposure that afforded me ways to further my leadership skills.”

HELPING NURSES BE THEIR BEST
When Jane Mosley, BScN 8T3, MScN 8T8, became the chief nursing executive at Women’s College Hospital, she said, “Nursing is a critical discipline for achieving excellence.” She stands behind her words.

Women’s College Hospital is the first and only stand-alone academic ambulatory care facility with a focus on women’s health, and it’s transforming the treatment of ambulatory care. “The innovations put into place are the efforts of many people, but I think it’s fair to say nursing has played a very important role in a number of important initiatives,” she says.

One innovation has been to change the way that nurses provide care to surgical patients so it significantly shortens the patients’ length of stay. Mosley has led studies to understand what works best in ambulatory care nursing and to learn how nurses can enable the most positive experience for patients. “This research led to a very strong nursing strategic plan,” she says.

Mosley reports that the master’s program gave her a greater appreciation for the research elements of nursing, as well as for the need to continue to learn and adapt in an ever changing environment. Now in a leadership position, Mosley is enhancing the role of nurses both in research and education. She doesn’t see herself as a born leader, though. Instead, she believes her experiences in various settings honed her skills and allowed her to grow into the role. “As a leader, my philosophy is grounded in the belief that every nurse can make an extraordinary contribution to their patients,” says Mosley. She welcomes the opportunity to help create an environment in which nurses feel supported to be their best. “And it’s certainly a privilege to do that,” she says. -

THE DECISION INFORMER

Over the past 20 years, the Nursing Health Services Research Unit (NHSRU) has provided rigorous research to inform decisions on how to build and sustain the nursing workforce and improve patient outcomes. And along the way, it has nurtured the careers of numerous researchers and decision-makers.

Bloomberg professor Linda O’Brien-Pallas, BScN 7T5, MScN 7T9, PhD 8T7, and Andrea Baumann at McMaster University in Hamilton founded the research unit in 1990 with funding from the Ontario Ministry of Health and Long-Term Care. They served as co-directors of the two-university collaborative effort until 2009.

Currently, Baumann and Bloomberg professor Diane Doran are the scientific directors of NHSRU’s research program “Building and Sustaining the Nursing Workforce for Better Patient Outcomes” which began in 2009 with funding from the Ministry’s Nursing Secretariat and Research Unit. A core team of researchers at the two universities are building on NHSRU’s past studies while incorporating its expertise, infrastructure and extensive partnerships with researchers and decision-makers.

Part of the NHSRU mandate is to continue to supply the Ministry with rapid-response information and time-limited studies to produce background data and evidence to support policy development. For example, NHSRU’s U of T site at the Lawrence S. Bloomberg Faculty of Nursing is evaluating the Late Career Nurse Initiative, which the Ministry introduced in 2004 to help reduce the loss of Ontario’s late-career nurses. Its other research areas include:

- the relationship between nurse-utilization patterns and health and safety outcomes for chronic disease populations;
- improvements in work life issues for correctional nurses;
- nurse staffing changes, quality work environments, and Health Outcomes for Better Information and Care (HO-BIC) across Local Health Integration Networks; and
- evidence-informed decision-making at the point of care.
The MN/MHSc Combined Program

READY TO TURN THE WORLD UPSIDE DOWN

Think our health care system needs fixing? These three master’s students have the moxie to make big changes.
As Alex Harris finished her BScN at Queen's University in Kingston, she wondered what to do next. On a whim, she Googled the three words that represent her interests: nursing, management, policy. Up popped U of T’s combined master of nursing and master of health science administration program.

The MN/MHSc program combines a foundation in nursing leadership with a health-services focus on policy, business and management. The Bloomberg Faculty developed the curriculum with U of T’s Department of Health Policy, Management and Evaluation in the Faculty of Medicine. It’s the only program of its kind in Canada.

But as Harris read on, she realized how select the MN/MHSc program is. Launched in 2005, it has only graduated four students. Never intended to be a large program, it’s aimed at those few individuals who not only meet all of the entry criteria, but who clearly articulate their future plans in health care leadership.

Last fall, three students, including Harris, were accepted. Here they share their perspectives on health care administration.

A BORN LEADER
Harris’s extracurricular activities won her a place in the program. While studying nursing, she was president of the National Health Sciences Students’ Association. “That’s when I got the politics bug,” says Harris, 24. “But I’ve always gravitated toward leading projects.”

When Harris graduates, she envisions working in policy, perhaps shaping nursing decisions with Health Canada. “We need to be a lot more collaborative in the way we think and practise,” she says. “I’ve always been a fan of inter-everything.”

YES, I CAN!
Recently, Clint Atendido took on the demanding position of manager of the Emergency Health System at Trillium Health Centre in Mississauga. He and his wife have a two-year-old daughter. And in the fall, he also became a full-time MN/MHSc student, attending two days of classes a week and handing in his essays on time. “You push on and find a way to get it done,” says Atendido, 35. “Besides, the program allows you to earn two master’s degrees in 2.5 years—that’s 1.5 years less than taking them one after the other. It’s actually saving me time.”

In addition to working at Trillium, for a time he also practised as part of an air ambulance team, providing critical care in the small passenger-hold of a Learjet. Through the combined program, Atendido is preparing to be a leader in community health care. “I want to impact more people than I would if I was a bedside nurse, but I love bedside,” he says.

While emphasizing prevention, Atendido wants to give responsibility back to the patients. “I would like to empower them to be knowledgeable about their illness and the care they ought to receive as patients in our complex health system.”

A GLOBAL VISION
Alexandra Schelck’s vision extends beyond our borders. With her MN/MHSc degree, she would like to work with an organization to improve access to paediatric care and delivery around the world. Or not. “Right now I’m keeping my options open,” says Schelck, 35.

After practising in the cardiac in-patient unit and cardiac ICU at the Hospital for Sick Children for seven years, Schelck began working with the Canadian Paediatric Surgical Wait Time Project. She still works with the project and finds her classmates’ support gives her the energy to carry the heavy course load. “Alex and Clint feel like family,” she says.
PERSPECTIVES on the “NURSING SHORTAGE”

Where there’s a nurse, there’s an opinion on whether there is—or isn’t—a nursing shortage.
Adequate staffing is tightly bound to patient safety. Researchers have repeatedly shown that having fewer patients per nurse or more nursing care hours per patient day is associated with fewer adverse outcomes.

In its 2009 health human resources report, the Canadian Nurses Association (CNA) addresses the need for a stable, sufficient supply of nurses. It looks to a framework developed by Bloomberg professor Linda O’Brien-Pallas and colleagues for strategies to ensure an adequate number of nurses today and in years to come. The CNA predicts that if measures aren’t taken, Canada will be short almost 60,000 nurses by 2022.

*Pulse* asked nurses to sum up their prevailing thoughts on and/or experiences with what has been coined the “nursing shortage.” As you’ll discover, the ideas expressed by the nursing leaders and scholars are reflected in the lived experiences of our recent graduates.

**Doris Grinspun**
Bloomberg Adjunct Professor, Executive Director of the Registered Nurses’ Association of Ontario

“Nursing shortage? Tell me where, and I will tell you when ... if at all! Shortage in many northern, remote and rural communities? Yes, a chronic shortage for which Ontario has done little to offer sustained relief, except for isolated policy initiatives such as the 1:1 tuition reimbursement for new grads relocating to underserved communities.

Shortage in Ontario as a whole? Not now. In fact, what we are experiencing is a shortage of employment opportunities for our new graduates and the replacement of hundreds of RNs by RPNs or unregulated care providers. So, let’s stop giving legs to the notion that we have an RN shortage, and let’s start by retaining Ontario’s RNs and offering them and all new RN grads full-time employment. This is what Ontario needs to optimize patient outcomes!”

**Rani Srivastava, MScN 8T6**
Bloomberg Assistant Professor (status); Chief of Nursing & Professional Practice, Centre for Addiction and Mental Health, Toronto

“Since I have been in the field of mental health and addictions, I have been struck by the realization that the stigma and mystery attached to mental illness extends to the nursing profession. It is hard to get nursing students and new nurses attracted toward and excited by a sector in which it’s hard to ‘see’ the nursing knowledge in action. At times of shortage, it’s more challenging to recruit nurses to this sector. For us, this means making sure we are more intentional and creative about communicating the opportunities that exist in this sector, and helping nurses understand how crucial they are at every step of the care process!”

**Sue McCutcheon, BScN 1T0**
Recent Graduate

“After completing an MSc, I announced I was going back to school to pursue a nursing career. Everyone thought I was crazy to enter a profession that’s understaffed and in which everyone is overworked. I dismissed their warnings, thinking it wouldn’t matter if you love what you’re doing.

“Now I’m a new RN at an acute care facility in a contract position, with no guarantee of permanency. Now I drag my feet as I walk home because I’m so exhausted; for the second time this week, I’ve done two hours of unpaid overtime. Now a break means I have a snack in one hand and a chart in the other. Now I understand what all the concern was about.”

**Kate Melino, BScN 1T0**
Recent Graduate

“I feel very lucky to have found a permanent, full-time position in mental health nursing, an area I am passionate about. The issues associated with the nursing shortage were immediately obvious to me when I arrived at the hospital; our orientation process had to be modified because the staffing need for nurses on the floor was so pressing.”

**Judith Shamian**
Bloomberg Professor (status), President of CNA

“CNA is deeply concerned about the lack of a pan-Canadian approach to managing health human resources. This tends to throw provinces and regions into competition with each other for much needed talent, and it makes Canada much more vulnerable to poaching from the U.S. as it seeks to hire many more RNs under ‘Obamacare.”

**Lucy Dong, BScN 1T0**
Recent Graduate

“Whenever the word ‘nursing’ is mentioned, the word ‘shortage’ follows closely behind. It seems that everyone believes there’s a high demand for nurses in the job market. However, as a new grad, it took me six months to get a full-time nursing position, and it’s only temporary. Even worse, I have friends in the same graduating class who are still seeking employment. The concept of nursing shortage just doesn’t seem applicable to us.”
If the decision to stay in nursing was just based on working conditions, many nurses would not stay employed,” says Bloomberg professor Ann Tourangeau. “The value and meaning of nursing work and the people they work with make nurses stay employed. Nursing is meaningful, fulfilling work. You make a difference with people, families, communities and society as a whole. Health is sacred to us all.”

The working issue many nurses find most distressing is workload. “Nurses constantly report being overworked,” says Tourangeau, who researches nurse retention. “The issue of workload has existed for 30 years and seems to be getting worse.”

The stress of trying to meet unrealistic expectations can make anyone feel overextended. Through the course of a nurse’s career, workload stress may lead to full-blown burnout. The process can begin on Day 1.

IN THE BEGINNING
Bloomberg professor Jessica Peterson, PhD OT9, who researches how to ease the
transition from student nurse to new nurse, acknowledges that the first year as a nurse is difficult. Newly graduated nurses require support, and it takes time to develop the speed and efficiency required in today’s busy practice settings. It can be especially difficult when senior nurses already have their hands full. “Experienced nurses are very busy,” says Peterson, an MOHLTC Nursing Early Career Research Award recipient. “Often, they want to help new nurses but can see teaching and assisting new nurses as requiring time, which adds to their workload.”

Not feeling comfortable about turning to a senior nurse for help can accentuate the stress that many nurses feel in their first years of practice, says Peterson. “When you begin practising, you’re afraid of being faced with a situation you can’t handle. You need to be in the role of nurse to know the full weight of the responsibility; you don’t get it until you experience it.”

Pamela Mitchell, our 2010-2011 Frances Bloomberg International Distinguished Visiting Professor, remembers being downright terrified when she began her career. “For my first six months of nursing I cried every day,” she recalls. “I kept expecting that I was going to kill someone.”

Not long after, though, she hit her stride while caring for a patient experiencing delirium tremors from alcohol withdrawal. “Suddenly it came to me that he was terrified,” recalls Mitchell. “I hugged him and told him, ‘We are not going to let anything harm you.’ This moment of empathy freed me to be empathetic with my patients, and to get inside people’s experience. It made being a nurse so worthwhile.”

I’M SO SICK
Perhaps no nurse is more enthusiastic about the profession than Bloomberg professor Sean Clarke. He beams ear-to-ear as he describes the diversity of opportunities it offers. “If you’re interested in people, there’s a place for you in nursing,” he says. Clarke adores how it combines both the life and social sciences. “Nursing is the coolest profession!” he exclaims.

Clarke’s zeal isn’t dampened by his research findings on the myriad occupational health dangers inherent in practising nursing. “Lower back injuries from lifting—it’s a big concern,” he begins. “And then there’s the problem of nurses in many specialities having to work on chaotic schedules, including night shifts; it turns the body’s internal clock upside-down. The science of how this affects the body is still developing, but many suspect shift work may place workers at increased risk for serious health problems.”

One of Clarke’s research areas is exposure to blood-borne pathogens through accidental contact with sharp instruments contaminated with blood. “Nurses are, by far, the largest single professional group at risk of sharps injuries,” he says. “At particularly high risk are new nurses, OR nurses and those who work where special teams are not used to do phlebotomies (blood draws).”

Sharps injuries put nurses at risk of serious blood-borne infections, including HIV, and hepatitis B and C. “The big concern is hepatitis C because it’s so contagious,” says Clarke. “Some estimate that three in 10 exposures from a sharp with hep C contamination will lead to a health care worker developing the disease.”

Clarke has found that sharps injuries are not random events, but are a consequence of nurse staffing and organizational issues. His early studies
showed that nurses could be twice as likely to get a needlestick injury on a unit with less adequate resources, lower staffing, less nurse leadership and high levels of emotional exhaustion.

Over the past decades, sharps injuries have fallen because many clinics and hospitals have switched to equipment designed to reduce the chance of an injury, reports Clarke. “However, the environments that nurses work in and the stresses they face continue to affect their risk of sharps injuries and other work-related health problems.”

**I'M SO TIRED**
The inability to fulfil job demands can exhaust you emotionally as well as physically. “If you have burnout, you have a complete lack of energy,” explains Mitchell, who has studied nurse burnout as part of her research on quality work environments. “Burnout can express itself as depression, or lead to depression.”

In a clinical setting, burnout may bubble to the surface as resentment, cynicism and anger toward colleagues. “Back biting, carping and bickering between nurses, and between nurses and physicians, becomes a vicious cycle,” warns Mitchell. “Usually, though, the patients don’t end up on the receiving end of a nurse’s burnout. Nurses seem to buffer the patients from their problems.”

An important key to preventing burnout is to have an element of control over your work and how it gets done, says Mitchell. “If you’re able to have some say about your practice, there’s less burnout. But in some hospitals, nurses are perceived as cogs in the wheel.”

To glimpse the personal impact of the work environment and other workplace demands, Bloomberg professor Linda McGillis Hall, MScN 9T3, PhD 9T9, led a study that included interviews with nurses who practise in hospital settings. “These narratives outlined the tremendous burden of guilt that nurses bear when factors in their work environment, such as workload, prevent them from providing complete, quality care,” reports McGillis Hall, who is also the associate dean of research and external relations. “A crucial finding was the extent to which nurses are affected by the adequacy of care they can provide. When the work environment prevents nurses from providing good care, they experience frustration and stress that impacts their work life, family and home life, and personal health.”

**LEAVING SO SOON?**
Tourangeau and team conduct research on how to encourage nurses to remain employed once they have chosen nursing as a career. They’ve found that nurses practising in acute care hospitals identify four priority situations that would encourage them to remain employed: a reasonable workload, a manageable nurse-patient ratio, a supportive manager and flexible scheduling.

“Retention is a complex issue with multiple influencing factors,” says Tourangeau. “But one thing we know is nurse retention challenges and obstacles may be less about nurses and more about the organizations in which nurses work.”

Take scheduling. “Many nurses don’t have control over their workload or their time,” says Tourangeau. “In hospitals where seniority determines who gets what shift, new nurses may not be able to get the desired time off.” In one of her studies, one nurse reported having to resign from her position because she couldn’t get time off for her own wedding.

Other factors affecting retention are the ability to secure full-time employment and receive formal support for graduate education, says McGillis Hall, an MOH LTC Nursing Senior Career Research Award recipient. “Many Canadian hospitals can’t offer this, but American hospitals can. So nurses leave. Unless we address the issues of nurse retention, the migration of Canadian nurses to the States will lead to a serious depletion of nursing human capital in our country.”
Quick! Name the top 3 patient-safety risks in home care. Don’t know? Neither does anyone else.
More than 900,000 Canadians receive health care services in their homes every year, and initiatives are underway to increase that number. Yet, there’s a dearth of knowledge on how to keep these clients safe. “We simply don’t know what the safety concerns are in home care,” says Bloomberg professor Diane Doran.

Régis Blais, a health services researcher at the University of Montreal, and Doran proposed generating evidence-based knowledge to help improve the safety of home care clients. Recognizing the need to inform home care policy and practice, the Canadian Patient Safety Institute (CPSI) and its partners awarded their “Safety at Home” investigation more than $1 million in research funds.

A NURSING ISSUE
Nurses are among the main providers of home care, and they report the patients they’re being asked to care for are more acutely ill than ever before. Doran understands their concerns not only as a researcher but as a former home care nurse. For five years, Doran practised with St. Elizabeth Health Care, visiting clients in Toronto’s Jane-Finch neighbourhood. Later, she helped St. Elizabeth form its first palliative care team.

Doran, one of the country’s most successful nurse researchers with 82 peer-reviewed publications to her credit, is ready to further her patient safety research. “I’m eager to fill the key information gaps in home care,” says Doran, who is also the director of the Nursing Health Services Research Unit, U of T site.

DOWN TO WORK
Doran and Blais’s 21-member multidisciplinary team will probe databases for a population-based analysis of adverse events (AEs), such as a medication error, pressure ulcer or fall that was caused by health care management rather than the underlying disease or disorder. They’ll look at 500,000 cases and do an in-depth audit in Nova Scotia, Ontario, Manitoba, British Columbia and the Yukon.

A unique feature of the study is that it’s also looking at the safety of the caregivers in the home. “We’ll be exploring caregiver burden and the impact of lifting on the caregivers,” says Doran. “You can’t separate the needs of the client from the needs of the family members caring for the client.”

THE KEY QUESTIONS
The “Safety at Home” study is probing several questions, including:
• What is the incidence of adverse events (AEs)?
• What are the determinants and risk factors for AEs?
• What practices have the potential to reduce avoidable AEs?

DIANE DORAN’S FINAL REPORT WILL LET US KNOW HOW CLIENT SAFETY CAN BE IMPROVED IN THE HOME

A safety risk, such as a scatter rug, but the family member or client has discretion for addressing that risk.”

While little is known about the safety of home care clients, the safety of hospital patients is well documented. In a 2004 study, for example, U of T researchers found 7.5 per cent of hospital patients experience an AE.

Doran can cite only two Canadian studies that have looked at safety risks in home care. One study, by a doctoral student, calculated the incidence of AEs in three Ontario home care agencies at 13.2 per cent. That’s almost twice that of in the hospital. Doran’s final report—to be released in January 2013—will let us know how client safety can be improved in homes.

The CPSI’s partners are the Canadian Institutes of Health Research, Canadian Health Services Research Foundation and The Change Foundation.

The key questions
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• What is the incidence of adverse events (AEs)?
• What are the determinants and risk factors for AEs?
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Home care not hospital care
One unique challenge of studying home care is that every home is different. Also, homes are unregulated environments. “The family has autonomy. A nurse can point out

BLOOMBERG NURSING
Innovation & Excellence in Care
A Conversation with Dorothy Wylie

**Pulse:** When did you become a nurse leader?
**Wylie:** In 1963, when I was promoted to head nurse in the recovery room at New York Hospital. But I had already been practising for a good 15 years. In New York City, I had worked at Columbia Presbyterian in the operating room. Later, I practised in Hollywood and San Francisco. When I came back to Toronto, I would always work at St. Michael’s—in emergency, on the obstetrics floor and then on a medical-surgical floor. But I was frustrated because I could do more than I was being asked to do.

**Pulse:** How did your education prepare you to be a leader?
**Wylie:** Nobody really taught leadership at that time. I trained at St. Mike’s, and we were trained to be handmaidens—to help and to do as you were told.

The public health course I took at U of T really wasn’t about leadership and neither was the bachelor’s of nursing program I did at New York University. I got my master’s at Columbia; we did nursing administration, but not much on leadership.

**Pulse:** So who taught you to be a nurse leader?
**Wylie:** Gladys Jones, the supervisor in the recovery room at New York Hospital. She was a take-charge kind of person, but wasn’t obvious about it. You never heard her chew anyone out, but if she didn’t like something you knew it.

Nursing wasn’t as rigid in the States as it was here. You had more of a collegial relationship with the medical staff; if you said something, they listened to you. I was encouraged to think, to voice my opinion, and not to just meekly go about my business.

**Pulse:** How were your relationships with the medical staff at Sunnybrook Hospital?
**Wylie:** Coming back to Toronto in 1970 was like entering the Dark Ages. The doctors were in charge, and you were just to do as you were told and not to think and not to have any initiative. When I became the assistant executive director of nursing at Sunnybrook in ’71, the doctors didn’t want someone else deciding what would be happening to their nurses.

I was constantly battling the doctors and I think that’s why I got burnt out. It was a struggle to get things to happen, and there was lots to do to change Sunnybrook from a military hospital.

**Pulse:** Did the nurses support you?
**Wylie:** I always felt we had untapped potential in nursing. But nurses, because of their rigid training, were autocratic and rule bound. They couldn’t think for themselves. Sometimes you have to bend the rules a bit if the situation demands it. The nurses found it very hard to use their judgment.
Fortunately, my co-workers at the senior level were supportive. We built K Wing for veterans, and we created such a wonderful environment. I am very proud of that.

**Pulse:** Then you tackled a bigger role at Toronto General Hospital.

**Wylie:** I was vice-president of nursing at the General from ’78 to ’87, and we had over a thousand nurses. It was a challenge and a half!

My predecessor had had a hierarchal structure, and I thought it was stifling. Everything went to the top. I would get questions from the units about situations I knew nothing about.

I felt we needed to be more democratic, so I created four divisions, each with a director, and then the head nurses reported to the director. When we got rid of some of those layers, the nurse manager got more responsibility.

**Pulse:** What have you learned about leadership?

**Wylie:** While I was at the General, I did a master’s in human resource development in Washington, D.C. I got all kinds of ideas about organizational development and leadership.

I learned to listen to people. The trouble with a lot of leaders is that when they get an idea, they push it down everybody’s throat. It doesn’t work that way. You need to find out what’s going on. If you want something to happen, you involve the people. Ask them, talk to them, get their ideas.

One of the things I did at the General was to conduct a survey of all of the nurses, so nurses could have some input into the direction we might go in. I also did workshops with the nurses. They were a way for me to listen.

**Pulse:** Is that when you started mentoring?

**Wylie:** I was always looking for nurses who were kind of different, who were renegades, probably because they were bored stiff. I would try to capture that energy and use it in a positive way. I just saw it as mentoring, but looking back it was cultivating nurse leaders.

**Pulse:** Any regrets?

**Wylie:** I wonder why I did any of it. Why was I so dedicated to nursing? I lived it all of the time. My mother didn’t understand me at all. But I have really enjoyed my life. I’ve been on 50 cruises!
I NOW PRONOUNCE YOU...

by PAMELA MITCHELL

Our Distinguished Visiting Professor says it’s time to permanently join together clinical and administrative research.

Why do you think the way that intensive care units are organized has anything to do with whether patients live or die?” Twenty years ago, when my colleagues and I began a research study to examine the contextual outcomes of ICUs, we were asked this question a lot. It was asked by nurses as well as physicians and administrative managers.

Florence Nightingale could certainly have answered the question—she convincingly demonstrated that having trained nurses, moving beds farther apart and instituting good hygiene practices in a field hospital in Scutari, in soldiers’ barracks in England during peacetime and in children’s bedrooms in orphanages in Australia markedly reduced the death rate from infectious disease. Indeed, the modern ICU is built on the assumption that grouping severely ill patients under the care of an adequate number of highly skilled nurses and physicians speeds recovery and saves lives.

There is some evidence that the hospital units that nurses consider to be a good place to work are also good places to be a patient. The communication between health care providers (for example, nurses, physicians and respiratory therapists) and with patients and their family members is a huge factor in how clinical care is delivered and, consequently, how effective any given treatment will be. When nurses and physicians operate with mutual respect and open communication, a nurse’s report of worrisome signs of patient deterioration prompts quick physician action. When this respect and good communication is absent, a nurse can find that his or her report falls on deaf ears, is misunderstood or simply ignored. In nationwide campaigns to reduce bloodstream infections in the U.S., progress is only made when nurses are given the authority to enforce the use of a “checklist” of good practices, such as handwashing, with other health care providers.

How does communication between health care providers and their patients affect recovery? Some hospitals make patients and their families truly part of the health care team; for example, they give them equal authority to call the Rapid Response Team. We don’t know if outcomes are better in these hospitals than in those where the patients and families are passive recipients of care—but we should try to find out. All of these organizational features, or contexts, definitely influence the number and severity of patient complications.

I fear we are once again disconnecting our understanding of the context of care from the content of care. I fear that the administrative and clinical arms of research are drifting apart with the advent of increasingly sophisticated clinical research about specific disease treatments and their effect on these diseases, and increasingly sophisticated health services and nursing administrative research about the financing and delivery of care. We know from the research on nursing health services systems that an adequate number of nurses is needed to prevent unnecessary deaths and complications. But we still need research about the care system as an intervention to uncover exactly how this “adequate number” works. Over the past 20 years, I have noticed some flirtation going on between clinical research and health systems (administrative) research. The time has come to make a commitment and marry them!
May 10
Nursing Week Celebration
At 5 p.m., come to a research exhibit that showcases the work of faculty members. Then at 6:30, a panel of leading clinicians, researchers and policy-makers will lead a discussion titled “Model of Care: Challenges and Opportunities.” A reception will follow.

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

May 12 and 13
Course: Managing Risk Factors for Older Adults in Acute Care
This Centre for Advanced Studies in Professional Practice (CASPP) course will help practising nurses identify common risk factors related to geriatric syndromes. It will include the essential interprofessional core competencies to enhance practice; and highlight strategies and tools for prevention, assessment, interventions and outcome evaluation. The program will include an interprofessional panel discussion on the challenges that older adults face in the health care system and when making a transition between settings. Complex patient scenarios will illustrate care challenges.

To learn more and register: Visit www.bloomberg.nursing.utoronto.ca or 416.946.7097.

May 28
Spring Reunion Lecture
As part of U of T’s Spring Reunion celebrations, Bloomberg professor Kelly Metcalfe will share her research findings on the psychosocial implications of various options to prevent breast cancer, including prophylactic mastectomy and oophorectomy. Metcalfe works with numerous international investigators and has developed a decision aid for breast cancer prevention in women with a BRCA1 or BRCA2 mutation. Her presentation—Women at High Risk for Breast Cancer: What are the options for prevention?—is part of the university’s “Stress Free Degree” lecture series. Metcalfe will speak from 9 to 10 a.m. at Sidney Smith Hall, 100 St. George St.

To learn more: Visit http://springreunion.utoronto.ca.

June 1 and 2
Course: Advanced Critical-Care Competencies Through Clinical Simulation
For more information on this CASPP course, please refer to the full-page description on page 29.

Spring Reunion
5 Years Out, 50 Years Out
The Bloomberg Faculty’s Spring Reunion on May 28 offers you opportunities to share memories with alumni from just about every graduating year. To get you warmed up for the event, we’d like to introduce you to Alison Thomas, who is marking her fifth anniversary since graduation, and Janet Ross-Kerr, a grad celebrating her 50th.

5 Years Out: Alison Thomas
earned a master’s of nursing and acute care nurse practitioner certificate in OT6. Since graduating, she has practised as an NP in the haemodialysis unit at St. Michael’s in Toronto. “The beauty of the advanced practice role in nursing is the diversity that it fosters,” says Thomas. “Along with clinical responsibilities, I am participating in leadership, education and research opportunities within the organization.” She’s also a member of the RNAO panel that’s developing a best practice guideline on decision support for adults living with chronic kidney disease and is researching the impact of implementing this guideline.

50 Years Out: Janet Ross-Kerr graduated with a BScN in 6T1 and has been busy ever since. She earned a master’s of science
Cindy-Lee Dennis
Appointed Shirley Brown Chair, Women’s College Hospital

In February, Professor Cindy-Lee Dennis stepped into a leading role in Canada’s drive to improve women’s mental health. As the newly appointed Shirley Brown Chair in Women’s Mental Health Research, Dennis will further her research into the social aspects of women’s mental health.

The Chair was established in collaboration with the Centre for Addiction and Mental Health, the Women’s College Research Institute and the University of Toronto. Dennis also holds the Canada Research Chair in Perinatal Community Health.

Want to Reach Out to Today’s Nursing Students?

As a U of T Faculty of Nursing alumnus, you’re invited to host a “Dinner with 12 Strangers” for students, faculty and your fellow alumni. The Faculty has a long list of nursing students eager to meet alumni over dinner, but no alumni to match them with.

“Dinner with 12 Strangers” emphasizes a social evening bursting with opportunities to engage with other members of the Faculty of Nursing community. When you sit down for dinner, you’re 12 strangers. When you stand up at the end of the evening, you’re 12 friends.

You design the evening. You can limit the number of guests...
to eight, or borrow your neighbour’s table and invite 12. Bake a tuna casserole and serve cookies for dessert. Or why not order in pizza from your favourite pizzeria? The evening is whatever you make it.

To host a dinner, please contact the Alumni Relations Office at development.nursing@utoronto.ca or 416.946.7097.

CNEs Do Lunch
In February, the Faculty invited chief nursing executives (CNEs) with the Toronto Academic Health Science Network to a presentation by Pamela Mitchell, the 2010-11 Frances Bloomberg International Visiting Professor. Mitchell’s talk—Evidence-Based Care: Creating evidence at the point of care—led to a productive dialogue among the 25 CNEs and senior staff who attended the luncheon event.

International Panel on Long-Term Care
In February, the Bloomberg Faculty hosted a “Care of the Elderly” panel, which featured nurse researchers from Ireland, England and the U.S. Professor Kathy McGilton moderated the panel, which was part of the two-day scientific meeting “Valuing the Role of the RN in Long-Term Care.”

Kudos!
The Bloomberg Faculty is proud to announce that the Council of Ontario University Programs in Nursing (COUPN) has selected one of our preceptors and an undergraduate student to receive awards of excellence.

In April, COUPN presented its Preceptor Recognition Award to Sunita Coelho at Women’s College Hospital for her essential contributions in providing direction, support and constructive criticism to a nursing student, and also for advocating for the profession. It awarded Margaret Saari, Class of 2011, the Excellence in Professional Nursing Practice at the Undergraduate Student Level Award for demonstrating excellence in nursing practice, leadership and scholarship.

In addition, Bloomberg faculty members nominated Sandra MacDonald-Renz of Health Canada for the Award for Strategic Contribution to Nursing Education and also Women’s College Hospital for the Agency Recognition Award. Both nominations were successful.

Associate Director of CASPP Appointed
Leslie Vincent has joined the Lawrence S. Bloomberg Faculty of Nursing as the associate director of the Centre for Advanced Studies in Professional Practice (CASPP). She brings to the position her depth of experience as a clinician, leader and nurse executive.

Vincent’s most recent role was senior vice-president, patient care, and chief nursing executive at Mount Sinai Hospital in Toronto. Prior to that, she held several positions in clinical practice and education in oncology nursing, as well as in administration.

She has served on many professional and public committees. In 2004, for example, Vincent was the only nursing member on the Provincial Expert Panel on SARS and Infectious Disease Control. She is also a past-president of the Academy of Canadian Executive Nurses.

Throughout her career, Vincent has focused on creating opportunities for continued professional development for nurses and for clinical specialization. As a longstanding status faculty member, she has worked closely with the Faculty on a variety of scholarly and professional collaborations.

CASPP offers a variety of advanced education opportunities, including innovative professional development programs, and RN and RN(EC) exam preparation courses. The programs are designed to help nurses advance their skills, enhance their knowledge base and move their career forward in exciting, challenging directions.

CONGRATULATIONS CRESSY AWARD WINNERS!

U of T allows the Faculty to formally recognize five nursing students who’ve made outstanding volunteer contributions to the Faculty and the university. This year, though, we insisted on bestowing six Cressy Awards. We have a bumper crop of exemplary leaders!

Graduate Recipients
Alyssa Hamilton, as president of the Graduate Nursing Student Society (GNSS), helped determine and then address the needs of grad students. She also represents graduate nursing students on the Graduate Student Union.

Barbara Mildon, BScN 9T3, MN 9T8, headed the development of national standards of practice for community health nurses, which led to the Canadian Nursing Association recognizing community health nursing as a specialty.

Kristine Newman utilized her role on the GNSS executive to mentor grad students and organize a monthly statistics workshop for fellow PhD students.

Undergraduate Recipients
Anna Bazylewicz was vice-president of the Nursing Undergraduate Society (NUS), and then last fall her classmates voted her president. She’s the nursing undergrad rep on the Sunnybrook Education Advisory Council, contributing to the hospital’s Education Strategic Plan.

Margaret Casey serves as the director of communications and an orientation leader with NUS. By encouraging her classmates to participate in social events and intramural sports, she helped create a vibrant student community.

Margaret Saari serves as the Faculty’s liaison for the U of T chapter of the Institute for Healthcare Improvement. In this role, she promoted student awareness of patient safety issues.
It’s unusual to see students sitting on the edge of their chairs in a policy class, but passionate debates about ethical dilemmas and energetic discussions on legal obligations keep Sean Clarke’s students enthralled.

Clarke is the inaugural RBC Chair in Cardiovascular Nursing Research at U of T and the University Health Network. He’s the author or co-author of more than 80 articles, 15 book chapters and the co-investigator on more than $10 million in research projects. And he teaches Bloomberg’s undergraduate course NUR410: Nursing and the Health Care System: Policy, Ethics and Politics.

While 410 is compulsory, it’s also enormously popular and highly rated. Few students skip class even though they don’t need to show up; Clarke records all of his lectures and posts them online. “It’s not the same—he’s better in person,” says Stephen Ng, Class of 1T1. “Sean makes a potentially boring course super fun with his engaging presence and by incorporating current news stories.” Ng says he’ll use what he’s learned in Clarke’s class as he works toward becoming a nurse practitioner.

Kate Hardie, our undergraduate chair, says many professors of his status would find it challenging to make the time commitment required to teach at the undergraduate level. “It’s obvious Sean considers it a priority to ensure entry-to-practice students have an in-depth understanding of the nursing context they will be employed in,” she says, adding that students consistently give his course a glowing evaluation.

Clarke is incredibly enthusiastic about the opportunity the course provides to empower students. “To have a hand in shaping the next generation of clinicians is one of the most important things I do to make a lasting contribution,” he says.

THE PERFECT COMBO
Nursing 410 and Clarke’s research both explore health policy and how systems influence patient outcomes. Clarke embraces the synergy that emerges. He says his teaching complements his research, and his research helps him to be a better teacher. In his lectures, he finds countless opportunities to use examples of safety and quality issues that have emerged from his research projects, collaborations and consultations as RBC Chair.

To ensure his students succeed, Clarke begins each semester with an FAQs handout that clearly outlines his and the course’s expectations. The goal is clear: provide students with the tools to help them build a career and eventually take on leadership roles in the profession.

LEADERS IN TRAINING
The course examines the health care system at multiple levels as well as some of the current issues and challenges of patients, nursing practice and the nursing profession. Students learn to apply the fundamentals of political action and policy analysis in a health care environment.

“If you understand how decisions are made, you can play a leadership role and influence the course of health care in general, in the country and in your institution,” he says. “There’s so much potential in the profession. We haven’t even scratched the surface of what nurses can do to make health care better.”
Time Travel

With her feet apart and firmly planted, this Faculty of Nursing student industriously mops the operating room floor. In 1949, when the photo was taken, one of a nurse’s major roles was to clean.

In the wards, nurses started the day by bathing the patients to prepare for the doctors’ early-morning rounds. They’d help their patients brush their teeth and comb their hair. When the doctors arrived, they were greeted by the smell of soap. The freshly scrubbed patients would be sitting upright in beds made with clean white sheets that the nurses had pulled taut and held tight with mitred corners.

The U of T student in this photo, though, would have done a lot less cleaning than a student in a hospital-based nursing program. On the wards, U of T instructors would ensure their students concentrated on patient care, not cleaning. In the OR, though, students were under the direction of hospital staff and were likely relegated to tasks such as cleaning the surgical instruments and rubber tubing used for blood transfusions.

Hospitals were sceptical of the clinical proficiency of university-trained nurses. This student, Lenore Mathews, would have been well educated in both patient care and public health. It’s highly likely that she chose not to work in a hospital after graduation but instead to go into public health, as did many of her classmates. Then again, Mathews doesn’t seem eager to pass her mop onto anyone else. You can almost see her jubilant smile behind the surgical mask.

U of T nursing student
Lenore Mathews hard at work
in the operating room, 1949.
This advanced course is designed for experienced critical care nurses. The Bloomberg Faculty of Nursing’s high-fidelity Simulation Lab will be used to help you update your knowledge, competencies and skills through interactive, hands-on learning.

Learn the latest evidence-based knowledge from various professionals who are experts in critical care.

Improve your critical thinking and decision-making for complex situations by using real patient scenarios.

**JUNE 2 & 3, 2011**

To register and for more information, visit [www.bloomberg.nursing.utoronto.ca/CASPP](http://www.bloomberg.nursing.utoronto.ca/CASPP) or email caspp.nursing@utoronto.ca.

Bloomberg alumni are eligible for a 15 per cent discount.
The Bloomberg Faculty of Nursing published more and was cited more frequently than any other nursing program in Canada or public university member of the Association of American Universities (AAU).

In research output and intensity, we're at the top of our class.

WE’RE #1

Counts of publications (articles, notes, reviews and proceedings papers) and citations are important indicators of scholarly impact, particularly in scientific disciplines such as nursing. Among all AAU members we came second only to the University of Pennsylvania.

The Bloomberg Faculty is among a select group of University of Toronto Faculties to rank #1 in Canada for publications and citations. The rankings are reported in U of T’s Performance Indicators for Governance, 2010, A Summary.

Congratulations everyone!

Data source:
University Science Indicators 2009 Standard and Deluxe Editions, Thomson Reuters