RESEARCHING ELDER-CARE SOLUTIONS
“I want to give homeless women a voice in their own health care. I couldn’t do that without these scholarships.”

CLARA JUANDÓ-PRATS
PhD Candidate, Nursing

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Cover: Bloomberg researcher Martine Puts. Photo by Paul Bettings.
Letters

NURSES GRIEVE, TOO
We were thrilled to see a focus on death, dying and bereavement in the Spring/Summer 2013 issue of Pulse. Thank you for bringing more awareness to this important topic.

As alumni of the University of Toronto – Beryl Pilkington, MScN 8T7; Cindy MacDonald, MScN 9T1; Eileen McMahon, BScN 9T8, MN 0T2, Post-Master’s NP Diploma 0T6, and myself – we would like to share with you and your readers a research-based documentary film we produced that addresses this important topic. Our film, Nurses Grieve Too: Insights into experiences with perinatal loss, is at http://vimeo.com/18714302

Thank you once again,
Christine Jonas-Simpson, MScN 8T9
Toronto

WORDS OF GRACE
I have just written a novel, Autumn’s Grace, about palliative care and one family’s journey from diagnosis to burial. The story illustrates the issues identified in the most recent publication of Pulse magazine – Dare to Dream of Better Endings.

Thank you for a brilliant production of the Spring/Summer 2013 Pulse magazine.

Best regards,
Bonnie L. Lendrum, BScN 7T7, MScN 8T6

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:

155 College St., Suite 130
Toronto, ON M5T 1P8

Published letters may be edited for length and clarity.
On August 1st, Sioban Nelson, the dean of U of T Nursing, assumed a new role at the University of Toronto, that of Vice-Provost, Academic Programs. In this position, Nelson will be directing academic standards, policy and planning for the university’s three campuses.

In 2005, when Nelson arrived from Australia to become dean, she said her job was to help the Faculty see how fantastic it is, to own it, and to set new benchmarks for the discipline and for ourselves. We are grateful for everything she has contributed, including forging strong connections with the teaching hospitals and broader professional community. Please join me in wishing Sioban all the best in her new role!

As Bloomberg Nursing’s Associate Dean, Research and External Relations, I was well prepared to step in and serve as the interim dean, a position that is both an honour and a challenge. The Faculty offers degree programs at the undergraduate, master’s and doctoral levels. There are more than 60 faculty members and about 400 adjunct faculty. And our Global Affairs Office is spearheading initiatives around the world. A lot goes into creating an outstanding professional faculty that ranks among the premier nursing programs in the world in both education and research.

In this issue of Pulse, we examine how best to meet the health care needs of our aging population. On these pages you may run into a classmate or one of your former professors who is pioneering innovative ways to care for the elderly. For example, you’ll read about alumni Anne Schofield and Janet Legge McMullan who are involved in launching nursing’s new rapid response role to ease the patient’s transition from hospital to home to primary care provider. Assistant Professor Martine Puts is breaking new ground with her research on how to best support elders faced with a new diagnosis of cancer.

You’ll meet some of the alumni behind the exemplary Acute Care for Elders (ACE) Unit at Mount Sinai Hospital, a unit where some of our undergraduate students are privileged to do a clinical placement. And almost half of our undergrads do a rotation at Baycrest, which the Ontario government recently recognized by funding it as one of only three Centres of Learning, Research and Innovation in Long-Term Care.

U of T Nursing is also taking a step forward by welcoming Anne Marie Rafferty as this year’s Frances Bloomberg International Visiting Professor. She’ll be working with the Faculty to advance our expertise in the research and policy arena by examining the contribution of nursing through the utilization of multiple data sources in long-term care settings. As well, she’ll explore the potential of developing a collaborative research agenda between the Bloomberg Faculty and King’s College, London.

It’s an exhilarating time for Bloomberg Nursing, and we look forward to sharing our excitement with you!

LINDA MCGILLIS HALL, RN, PhD, FAAN, FCAHS
INTERIM DEAN
A call for warmth and compassion

When robots are being considered to help care for the elderly, it’s time to pause and rethink.
Seniors make up Canada’s fastest-growing age group. An increased life expectancy and the aging of the Baby Boomers contribute to our aging population. This high proportion of seniors is unprecedented in Canadian history. In the 1920s and ’30s, for example, about one in 20 Canadians was 65 and older. But by 2051, it’s expected that one in four Canadians will be a senior.

Over the years it has become common practice for older persons to be placed in nursing homes or homes for the aged for care provision. While legislation requires that a nurse be on site in nursing homes at all times in Ontario, this requirement seems to pay little regard to the acuity of the residents. The Canadian Institute for Health Information recently identified that the proportion of residents in Canadian nursing homes with disease diagnoses increased for every category of disease between 2008 and 2012, suggesting an increase in the residents’ overall acuity. Yet corresponding increases to nurse staffing levels have not been seen to match the needs of this changing population.

In fact, the requirement for “a” nurse on site may be used as a minimum standard, rather than determining staffing levels based on resident needs and expected standards for quality resident care. As Canada struggles with cyclical nursing shortages, these challenges become even more acute.

Who will care for our elders? Will Canada’s long-term care settings be able to provide elders with the health care and other services they require for quality resident care? Nurses are leading initiatives to address these questions. But one has to wonder if this bulge in the elderly population is so unusual that it’s creating somewhat unusual solutions, including the use of robotic technology.

**ROBOTIC REPLACEMENTS**

The idea of using robots to help care for the elderly is gaining ground. As far back as the 1980s, robots were described in Japan as having the potential to replace the family in the care of elderly family members. Now, three decades later, the entire June 2013 issue of the *Journal of Gerontopsychology and Geriatric Psychiatry* is devoted to the use of robots in elder care. The journal introduces you to Care-O-bot, a robot that can fetch and carry drinks, play memory games and assist in the performance of activities of daily living. Telepresence robots, such as Giraff, allow staff to monitor and interact with residents in long-term care facilities without leaving the nursing station. They also allow caregivers to virtually visit clients in their homes through the Internet. Both of these models are thought to provide or replace functional care, but they do not address emotional aspects of care.

The robot that’s garnering the most attention in elder care circles is Paro, a white stuffed animal that some say gives emotional support. These social robots were introduced, in part, as an innovative strategy for dealing with the aging population to provide companionship, social interaction and facilitate independence. Some devotees purport that Paro can break through the communication barriers caused by Alzheimer’s and dementia. Then there are those who rail against the indignity of a robot taking the place of human companionship. They express concern that robots minimize human contact and deprive older people of much needed human touch and emotional warmth.

Takanori Shibata in Japan, who invented Paro, modelled it after the baby harp seals he saw when he visited the Canadian North. The sounds that Paro makes are Shibata’s recordings of baby seal cries. Paro looks like a cuddly toy you might win at a carnival game, but beneath its faux fur are hundreds of tactile sensors. Its metal skeleton contains a 32-bit computer and three microphones. And although Shibata did not give Paro a beating heart, the stuffed animal can...
finding that Paro has a multitude of uses. For example, the furry robot can help agitated individuals calm down, and reduce restlessness, aggression and wandering behaviours. Some authors suggest Paro supports the health care team if incorporated as a care intervention. These interventions could be aimed at increased physical activity such as motivating patients or residents to walk to Paro, or evoking emotions to improve mood or reduce loneliness.

While robots may add value to some aspects of care that nurses, personal support workers and countless others provide for older people, they cannot replace the care that nurses and health caregivers deliver. The emergence of robots in the care of the elderly provides evidence that nurse staffing in long-term care is a global concern. How did we get here? How is it that the elderly, often the most revered members of our families and society, are provided with care predominantly from the least skilled care providers in the health care system? How is it that the “new normal” around the globe may come to be one of supplementing nursing care with robots?

It is well known in the health care system that acute hospital care is much more richly resourced than long-term care settings. And facilities that are well resourced are attractive work settings for nurses, as they typically offer higher salaries and better benefits. At the same time, the resident care needs in long-term care settings have changed, becoming more complex and requiring multiple interventions from a higher skilled worker to maintain quality care.

Yet this shift has not been matched with a change in staffing practices, or a corresponding increase in the desire by the higher-skilled registered nurse to seek employment in long-term care. Instead we see the introduction of the Paro seal into long-term care environments in some parts of the world. So far, robots may not be replacing staff, but even entertaining the idea that a robot is an alternative to providing emotional and social care should give us pause. Perhaps it’s time to look at the evidence and rethink what is the “best” care that can and should be provided to the elderly in Canadian society, who should be providing that care and what needs to be done to make this happen.
The STIGMA of getting OLD

Why do we close our eyes to the elderly?

“IT WAS A WAKE-UP CALL FOR ME,” admits Gail Donner, who chaired the Long-Term Care Task Force on Resident Care and Safety. “I’d go home and ask, ‘How did I let myself not see this? Why did I brush this aside?’ I could have advocated more for this population.”

The Task Force was established in November 2011 in response to media reports of abuse and neglect in long-term care homes and the potential for these incidents to go under-reported. The Task Force included members of the long-term care sector, professional associations and unions, as well as
frontline workers, administrators and health care providers. “We all recognize the importance of addressing abuse, including patient-to-patient abuse,” says Gail Paech, who served on the Task Force as the chief executive officer of the Ontario Long Term Care Association. “It’s an issue that doesn’t have an easy fix.”

“I have a 100-year-old mom who has been blind for 15 years, is on 24/7 oxygen and lives on her own in an apartment,” says Dr. Donner, a former dean of U of T Nursing. “I really care about the elderly, but I have no background in elder care. So my job on the Task Force was to help the members use their expertise. I went in as a facilitator, but the whole issue of elder care seduced me.”

THE UNEXPECTED
Donner’s first awakening came when she began to meet some of the residents of long-term care facilities. “I was shocked at the changing face of who is in long-term care. It’s a myth that long-term care is full of little old ladies drinking tea.”

Paech, a former U of T Nursing assistant professor, explains that the resident profile has indeed changed. “Years ago, people would stay in a long-term care home for four years and would enter at a much younger age. Now the average stay is just 18 months, and the average age on entry is 85. And one of the big changes is that they’re usually entering not only with multiple co-morbidities, but a cognitive impairment.”

“These residents need sophisticated care,” says Donner. “We need more education for frontline workers. We need to give them the skills to care for residents with a mental illness or cognitive impairment that can cause difficult behaviours. When a nurse has a patient who thinks she’s the devil, that nurse needs to know how to de-escalate the situation.”

While remarking on the “incredible dedication” of the nurses who choose to practise in the long-term care sector, Donner says their choice is not a popular one. “The pay is low, and their friends will ask, ‘What? You can’t get a job in acute care?’”

The fact that caring for the elderly holds little to no appeal for many is more than ageism, she says. “We don’t want to know about people who don’t know, who are not cognitively intact, who are past the stage of what we consider ‘contributing.’ It’s a stigma.”

WHAT’S YOUR HOME LIKE?
“The whole standard in long-term care needs to go up,” says Donner. “We have some great homes, and we have homes that are not great places. We need to see that there’s a basic minimum standard.”

The Task Force’s mandate was to develop a plan to examine and address the factors contributing to abuse in long-term care. To inform their work, the members consulted with more than 40 experts in the field and received close to 2,000 completed surveys from individuals and groups. “I read all of those 2,000 surveys,” says Donner. “Some of what I read kept me awake at night. The way we treat the most vulnerable is frightening.”

“Look at the social determinants of health affecting older Canadians,” challenges Michael Villeneuve, a Bloomberg lecturer and graduate faculty member. “Many seniors have one or more chronic diseases, are socially excluded, live on a fixed income and have poor nutrition, and all of these determinants can challenge health. Seniors can be extremely vulnerable.”

Since the Task Force released its report, An Action Plan to Address Abuse and Neglect in Long-Term Care Homes, more than a year has passed. The report identifies 18 actions to improve the care and safety of long-term care residents. Eleven actions focus on areas in which the long-term care sector can play a leadership role and six require leadership from the Ministry of Health and Long-Term Care. And the 18th action plan is to keep on going. The team is following up on its proposals and publishing semi-annual reports to chart its progress.

DON’T PUT ME IN A HOME
As the Task Force pushes forward to improve safety and care in long-term care facilities, the movement to care for the elderly at home is gaining momentum. “The thrust is to provide services where people live, to maintain seniors’ health status by keeping them in the community,” says Paech. “This population does not want to be institutionalized.”

In 2012, the Ontario Long Term Care Association convened the Long Term Care Innovation Expert Panel, and Paech was a member. The Panel maintained that elders should be supported at home for as long as possible. The Panel’s vision was for long-term care homes to be hubs for community-based care and geriatric research and education. It recommended that providers and policy-makers set a goal to reduce the overall length of stay in long-term care homes while increasing short-stay capacity for respite and convalescent care. “It’s all about optimizing the length of stay,” says Paech, who served as Ontario’s associate deputy minister of health and economic trade and development from 1998 to 2011. In this capacity, Paech introduced short-stay services, which enable individuals who have broken a hip or had a heart attack, for example, to stay in a long-term care facility until they’re strong enough to return home.

A MAZE OF SERVICES
“It needs to be much easier to access services,” continues Paech. “You could have a specialist for your heart and others for your diabetes and rehabilitation, making the system so complex that people are overwhelmed by it. We have to make it simpler and friendlier to family members.” Due to the complexity of the system, Community Care Access Centres are enhancing the role
of case managers. And to capitalize on people’s frustrations with our convoluted health care system, a new role has emerged in the private sector – that of the health care system navigator. “Health care services need to be seamless,” says Paech.

“We absolutely must be seamless,” echoes Villeneuve, BScN RT3, MSc 9T3, who was the executive lead of CNA’s National Expert Commission. “We need structures to share information. It’s like our health care providers are still communicating with a quill pen. Communication in our health care system is medieval!”

“Through the electronic health record, much more information is being shared,” says Paech. “Electronic records can really improve the co-ordination of care.”

Villeneuve takes a piece of paper from the top of his desk and starts waving it in the air. “My dad stayed in the hospital from April 23 until the end of August and was discharged with a one-page report that said he’s a new dementia patient. Where are those electronic records for the users of the system? It’s entirely provider focused and even then, only a narrow range of items are digitalized.”

AN EXERCISE IN FRUSTRATION

“My sister and I experienced pushback at every point,” continues Villeneuve, whose father suffered two strokes this year. “We have had to fight for everything, and we know a lot about the health care system. My sister is a social worker and I’m a nurse, but we struggled and struggled to try and get the health care system to work for our father. What would have happened to my dad if I couldn’t speak English? What would have happened if he was alone in the world?

“The first problem we ran into had to do with inequity because of where he lived,” he continues, explaining that his father, now 82, was living in Bracebridge, Ontario, at the time of his first stroke. “Canada still has terrible disparities based on geography.”

Villeneuve’s father spent five weeks in an acute-care bed in Bracebridge, waiting for a place in a rehabilitation facility in Toronto where his children could visit him and be involved in his care. “The life-saving and treatment side of our health care system is terrific, but we don’t know what to do with the patients after we’ve saved them. My dad isn’t unusual. Brain injuries aren’t unusual,” says Villeneuve, whose clinical experience includes being a patient care manager in the neurosciences intensive care and spinal cord injury units at Sunnybrook Health Sciences Centre. “There are a whole lot of people with various dementias and more on the way.”

With the aging of Canada’s population, the incidence of dementia is going nowhere but up. Villeneuve invites you to visit the Alzheimer Society of Canada website, where the Society has posted its forecast – that by 2038, one person will be diagnosed with dementia every two minutes.

“We’ve built a hospital system, not a health system,” he says. “All of the money goes into acute care. If you’re trying to get an aging parent into a long-term care home, good luck to you! The further you get away from a hospital, the less we value it and the less money we put into it. You can wait 18 months to two years to get into a long-term care home. And for lots of facilities, you can wait even longer. There simply is no surge capacity in the system when a new stroke patient, like my dad, appears on the scene. At every step you wait. And in Dad’s case, that meant several weeks in an acute, medical-surgical bed.

“After he was discharged from the hospital, we paid privately for 24-hour sitters to keep a wandering, confused, dementia patient in a retirement facility because the system was utterly unable to offer any other options. We had my father’s insurance and pension to help with the cost, but what would Canadians without these resources do?

“For weeks, we contacted all sorts of rehabilitation facilities to ask if they could help our dad,” Villeneuve laments. “Everybody rejected him, and they didn’t really tell us why. They just wrote back, ‘He’s not appropriate for our program.’ Finally, one rehab centre agreed to take him. “The public is ready for change, and I believe we’re on the cusp of something. Change isn’t impossible and we don’t have to start from scratch. We can look to Denmark and Alaska for interesting models of community-driven care. Politicians are looking at innovation and scope of practice. So despite my frustrations, I still feel hopeful. But to address the complex range of health problems that Canadians are living with every day, we have to loosen our death grip on acute care.”

“Please keep the blanket on the patient all the time.”
Learning can sneak up on you when you least expect it

The night before Brian Malecki started a clinical placement at Baycrest, he couldn’t sleep. “I was extremely nervous,” recalls the undergrad. “I’d only started the nursing program two weeks earlier.”

The next day Malecki found himself in a complex continuing-care unit, helping patients brush their teeth, shower and get dressed. And before long, he was suctioning a tracheotomy. That afternoon, he couldn’t wait to get home and tell his wife, who is also in the Class of 2014, about the trach. In the evening, Malecki phoned his parents. “Guess what I did today?” he asked.

Baycrest, which is fully affiliated with the University of Toronto, is one of the world’s pre-eminent providers of knowledge in best and leading-edge practices in senior care and aging solutions. Every year, its extensive clinical training program in geriatric care involves 1,100 students, trainees and practitioners from 39 universities and colleges from across Canada and around the world. Close to half of U of T Nursing undergraduates do a clinical rotation at Baycrest.

The Ontario government recently recognized Baycrest’s leadership in elder care by funding it as one of three Centres of Learning, Research and Innovation (LRI) in Long-Term Care. Developing frontline health care providers to meet the needs of long-term care residents is part of the strong educational focus of Baycrest’s new LRI Centre, which is housed within the Baycrest Centre for Education and Knowledge Exchange in Aging.

But often, some of the most important learning doesn’t come from an
educational focus or an established curriculum. It happens by accident.

“The patients at Baycrest have lived rich lives, and I grew through hearing about their experiences,” says Malecki. At Christmas, when he visited his family’s farm in Drumbo, Ontario, he had what he calls “an epiphany moment.” From watching the Baycrest nurses interact with patients, he discovered that he had learned how to initiate and engage in a conversation with an older person. “Now I feel much more comfortable conversing with my grandfather,” he says proudly.

WHAT’S NEXT?
Central to Baycrest’s educational strategic plan is a commitment to scholarship, best practices and next practices. “We are exploring and testing new models, innovations and approaches to care to meet the realities of the practice setting,” explains Faith Boutcher, MSc 9T2, the director of academic and interprofessional education at Baycrest’s Centre for Education and Knowledge Exchange in Aging. “For example, interprofessional care has generally not been explored in long-term care, even though residents are extremely complex and require a collaborative approach. So we’re building interprofessional competencies into our training programs for staff and students, helping them learn how to address complex care needs in collaborative ways.

“We’ve been exploring the use of arts-based learning and theatre as innovative methods to engage staff and students,” continues Boutcher, who is also a U of T Nursing adjunct faculty member. “We’ve found that these educational approaches foster interaction, provide a positive learning environment, and enable staff and students to integrate the essential elements of collaboration into care.”

Interaction was the cornerstone of Nisha Stephens’s Baycrest placement. In a rehabilitation unit for elders working toward discharge following hip replacement surgery or a stroke, the Class of 2014 student bonded with a patient whose room was decorated with personal photographs. Some of the photos were of the woman in her younger days carrying a canoe high above her head. “I like portaging too,” exclaimed Stephens, settling in to exchange paddling tales.

In the summer, Stephens interned at the Hospital for Sick Children and instantly noticed a disparity in the care of the very old and the very young. “At SickKids, there are always volunteers poking their heads into the patient rooms and asking to help out or engage the child in play. And there are clowns walking around in the halls. Geriatrics seems to have a lot less money and a lot fewer services. The patients sit alone in their room a lot of the time. We need more volunteers to visit the elderly.”

AN ONGOING JOURNEY
“I’m always trying to turn people on to geriatrics,” says Anne Marie Shin, Baycrest’s executive director of nursing, quality and safety and a Bloomberg adjunct faculty member. “Geriatric nursing is very much undersold. It allows critical thinking and you’re given autonomy. There’s so much potential to impact the day-to-day quality of life for the patient.”

Earlier this year, Shin worked with Dr. Francine Wynn, the director of our undergraduate program, in redesigning the Baycrest rotation to expose students to the breadth of geriatric nursing. “This year, the undergrads will have an in-patient experience, but also participate in experiences such as a day centre for the elderly and home visiting,” says Shin, BScN 8T9, MN 1T0.

It was exciting for Shin to collaborate on this initiative because Wynn was one of Shin’s favourite U of T Nursing teachers. “Francine always took a different perspective, a perspective that stretched us. And she’s so patient focused. She’d say, ‘Don’t nurse the machines, nurse the person. Look at the person, not the machine. The bath is not just a task. It’s all about building the therapeutic relationship.’”

Baycrest staff Anne Marie Shin (left) and Faith Boutcher go over teaching notes with Brian Malecki, one of U of T Nursing’s undergraduate students
This Bloomberg assistant professor is exploring how to support elders facing a tough decision about a tough diagnosis – cancer.

Cancer is predominantly a disease of older adults. In Canada, almost half of all new cancer diagnoses are in individuals who are 70 and older. Yet guidelines for treating cancer in the elderly are scant.

“It’s a very new field,” says Martine Puts, one of the few researchers in Canada to have trained both in geriatric oncology and epidemiology. Dr. Puts’s research has led to numerous published articles in a wide range of scholarly journals.

While growing up in the Netherlands, Puts found herself being drawn to seniors. “The elderly are fascinating and so willing to share their life experiences,” she says. Her respect for the aged fuels her research purpose: to contribute to best clinical practice guidelines that inform the practice of physicians, geriatric oncology nurses and other health care providers working with older adults who have cancer. Her research will also help determine how best to support older adults undergoing cancer treatment maintain their health and functional status.

A RAINBOW OF PILLS

As age increases, so do the number of chronic conditions an individual has. “On average, older adults take six or seven prescription drugs a day to manage their health problems,” says Puts. Then there’s the new diagnosis: cancer. And
along with the physical, emotional and spiritual challenges of cancer can come more pills.

“Pills to treat cancer have to be taken on a strict schedule,” explains Puts. “Many of those pills are taken three or four times a day. Some need to be taken on an empty stomach, some on a full stomach, some with water. Others can’t be taken with certain foods, such as grapefruit juice. The regimens are complex for anyone, and it’s a whole-day task to take the pills correctly.

“Some cancer treatments involve taking eight pills a day, and an older patient may already be taking eight pills a day for other health problems. If it’s the 16th pill you have to take in a day, some seniors may simply say, ‘No thank you.’”

The decision to omit doses of cancer medication can have serious consequences. Taking the drugs as prescribed is crucial for achieving desired outcomes, such as increased survival. But research shows that in the elderly, as the number of medications increases, adherence decreases.

As a Connaught New Researcher Award recipient, Puts is exploring the factors that influence an older adult’s adherence to cancer treatment regimens. In addition, with a Canadian Institutes of Health Research Knowledge Synthesis grant, she’s looking at the factors that contribute to an older person’s decision to accept or refuse cancer treatment. “It’s important to understand the reasons behind the behaviour,” says Puts.

**A PANORAMIC VIEW**

“When you use the geriatric lens, it’s necessary to look at the whole person,” she continues. For instance, socio-economic factors, such as a low income and lack of transportation, can influence treatment decisions. “The out-of-pocket expenses for cancer treatment can add up to thousands of dollars,” explains Puts. “If a woman is undergoing radiation for breast cancer, that’s 25 days that she might need to take a taxi to the hospital.”

Being socially isolated can also sway treatment decisions. “If an older person lives alone, the person might worry about how to pick up medication from the pharmacy if they’re not feeling well.”

Further complicating cancer treatment decisions are the physiological changes that come with aging. “It’s difficult to identify what therapy is best for the elderly,” says Puts. “Many drugs are excreted by the kidneys and because of the aging process, drug clearance may be slowed, making older adults vulnerable to toxicity and side effects. And because older adults often take many drugs at the same time, the drugs might interact and cause adverse drug events leading to hospitalization, morbidity and mortality. At the moment, there is no tool that can accurately predict who is at high risk for toxicity from the cancer treatment and who can tolerate it well.”

In addition, physicians don’t have large drug trials to inform their recommendations for older adults with cancer. The elderly, and especially frail older persons with co-morbidities, are under-represented in clinical trials. “It’s understandable,” says Puts. “All oncology trials are a big gamble, there’s quite a significant risk. But the exclusion of the elderly with other chronic health conditions from drug trials possibly results in less-than-optimal cancer treatments. Due to the lack of clear treatment guidelines for older adults, the elderly have been known to be under treated and over treated.”

A geriatric assessment, though, can help healthcare providers identify which older patients are fit to undergo standard cancer treatment and which would benefit from modified treatment or palliative care. This multidisciplinary assessment evaluates the older adult’s medical, psychological, social and functional capacity.

In 2012, Puts was the principal investigator on the first review that systematically summarized all evidence on the use and effectiveness of geriatric assessment in the oncology setting. “A geriatric assessment may not be practical for every older adult who comes to an oncology clinic,” warns Puts. “It takes one-and-a-half to two hours for an interprofessional team to complete a geriatric assessment. And at the moment, we don’t know which group of older adults are likely to benefit from an assessment.”

The International Society of Geriatric Oncology has recommended that a geriatric assessment be conducted to help cancer specialists determine the best treatment for their older patients. “The organization is silent as to what constitutes the best form of assessment,” says Puts. “There is no consensus yet on what that geriatric assessment should be. And there is a dearth of studies examining if a geriatric assessment influences care decisions and improves important outcomes, such as quality of life.”

Much is still to be learned about which older adults will benefit from standard treatment and which won’t. With the aging of the population, the need for that knowledge is becoming urgent. “As you age, your risk of getting cancer increases,” says Puts. “Most people don’t die healthy in their sleep.”
I’ll be right there

The Ministry of Health and Long-Term Care has provided funding for 126 registered nurses to help care for some of Ontario’s most vulnerable through the new Rapid Response Nurse (RRN) Program. Working through the province’s 14 Community Care Access Centres (CCACs), an RRN delivers transitional care for patients discharged from hospital by providing the first in-home nursing visit within 24 hours. The nurse offers education about the patient’s disease, connects the patient with the care he or she needs, and ensures that the client is correctly taking any medications that have been prescribed. To be eligible for the program, an individual must have a medically complex, serious condition or be considered vulnerable. The vast majority of the patients are elderly.

“It’s an excellent new role,” enthuses Bloomberg Professor Emerita Diane Doran, a co-author of the recently released Safety at Home: A pan-Canadian home care study. “In our research, we found that the highest risk of an adverse event is within the first 30 days after discharge. Most at risk are the elderly because they often have complex needs and multiple co-morbidities.” This provincial initiative aims to reduce the risk of re-hospitalization. And an adverse event – such as an infection, fall or medication error – can land the recently released patient right back in a hospital bed.

To transition a patient from hospital to home, the RRN determines if additional resources are required. Working with a CCAC care co-ordinator, arrangements can be made for an occupational therapist, physical therapist, personal support worker, social worker or registered dietitian to assist the client. If the RRN requires more than the initial 1.5- to two-hour visit to link the client with appropriate home supports, the nurse may visit again or arrange for a “phone visit.”

To further ensure client safety at home, the RRN determines if additional resources are required. Working with a CCAC care co-ordinator, arrangements can be made for an occupational therapist, physical therapist, personal support worker, social worker or registered dietitian to assist the client. If the RRN requires more than the initial 1.5- to two-hour visit to link the client with appropriate home supports, the nurse may visit again or arrange for a “phone visit.”

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TEACH ME
A significant component of the RRN role is helping clients understand their illness. It starts with the RRN going over the discharge information with the patient. RRNs use the “teach back” approach – in which the patient repeats back what the nurse has said – to assist clients in retaining self-care information.

“Helping patients to recognize signs and symptoms is so important,” says Anne Schofield, MN 0T3, who practises in the ambulatory outpatient heart failure clinic at Mount Sinai Hospital in Toronto. “When patients get home they can take a tailspin.”

The RRN teaches self-management strategies by asking the client: What do you do if this happens? When should you go to your primary care provider? When should you go to the emergency department?

The teaching doesn’t stop with a conversation in the comfort of the living room. With heart failure patients, the RRN might ask to look inside the client’s kitchen cupboards, reports Schofield, who is also a Bloomberg...
Helping launch a new role
Earlier this year, the Ontario Association of Community Care Access Centres (OACCAC) engaged U of T Nursing’s Centre for Professional Development to deliver a two-day Rapid Response Nurse Learning Institute. A number of Bloomberg alumni and adjunct faculty taught in the groundbreaking course, which was offered in February and then again in April.

“The Centre for Professional Development also handled the logistics and administrative side of registration, and co-ordinated the institute. It was a very positive collaboration.” says Janet Legge McMullan, BScN 8T2, MN oT6, who lectured at the institute, including on how to screen older adults for the 3Ds: dementia, delirium and depression.

About 60 nurses and nurse managers from across Ontario who would be working in the new Rapid Response Nurse (RRN) Program attended the institute. “The nurses chosen to be RRNs are a clinically astute group,” says McMullan, an OACCAC client services specialist. “The majority of the nurses hired have extensive acute or emergency department experience.”

As part of the institute, the delegates used our Nursing Simulation Lab to master the skills needed to assess and manage congestive heart failure and chronic obstructive pulmonary disease. During this four-hour lab, they learned how to perform a focused physical assessment. “Rapid response nursing is such an important clinical role,” says McMullan. “RRNs are the early eyes on patients and support them in transitioning home safely.”

adjunct faculty member. “The goal for patients on a low-sodium diet is 2,000 or fewer milligrams in a day, and a lot of soups have 700 or 800 milligrams of salt – per serving!”

Medication reconciliation is another service RRNs provide. Many patients go home from the hospital with different medications, but also have medications at home that they were taking previously. And if they’re uncertain about medication changes on returning from hospital, some simply go back to their old drugs.

“It’s crucial to identify what medication changes were made in the hospital and make sure they’re adopted at home,” says Schofield. “If their diuretic dose isn’t right, they can lose too much fluid, dehydrate and suffer an acute kidney injury. Or, they can retain more fluid and end up back in the hospital.”
Combining Strengths

LAST YEAR, THE CHIEF NURSING
executives with the Toronto
Academic Health Science
Network (TAHSN) met
with Bloomberg faculty members
to discuss the possibility of estab-
lishing a network of scholarship for
erler care. “There was a real synergy
to move forward,” recalls Associate
Professor Kathy McGilton.
“The timing is perfect,” adds
Anne Stephens, a Bloomberg adjunct
faculty member. “We can build on existing initiatives, such as the
Ontario Senior Friendly Hospital
Strategy led by Local Health Integra-
tion Networks and co-ordinated by
the Regional Geriatric Program of
Toronto.
“The Toronto Central LHIN has a
strong commitment to the care of
older adults and has systematically
supported the development of a Sen-
ior Friendly Hospital Framework that
places a top priority on the preven-
tion of functional decline,” continues
Stephens, a clinical nurse specialist
with the Toronto Central Community
Care Access Centre. “It doesn’t really
matter how geriatrics gets to the for-
front, just as long as it gets there.
“The TAHSN/U of T Elder Care
Initiative is on the brink of contrib-
uting scholarship,” says the alumna.
“I think it’s very, very exciting.”

DON’T SLIDE DOWNHILL
One of the Initiative’s major goals
is to develop broad guidelines for
preventing functional decline,
which it conceptualizes as “deteri-
oration in one or more activities
related to activities of daily living
(such as dressing, toileting and
bathing) and/or mobility.”

While hospitalization provides
high-level care during an acute ill-
ness, it exposes older patients to the
risk of losing their ability to return
home – whether home is an apart-
ment, retirement residence or their
daughter’s house. A decline in the
ability to toilet independently, for
example, could mean a senior needs
to move into a long-term care facility.
“We can create more disability for
the patient than what he had when
he walked in,” warns McGilton,
BScN 8T7, MScN 9T3, PhD 0T1.
“Much of this in-hospital functional
decline is preventable, which makes
it important for the TAHSN facilities
to work as a collective to prevent it.
“The network is a wonderful
opportunity to share best informed
practices between sites, thereby
improving efficiencies,” she con-
tinues. “The combined effect of
multiple programs within differ-
ent hospitals will be muted in the
absence of a forum to organize
them.”

Stephens, a lead on the Interven-
tions Targeted to Prevent Functional
Decline Working Group, is helping
to develop recommendations on
what TAHSN hospitals can do to pre-
vent or reduce functional decline.
The group would also like to col-
laborate with the Initiative’s three
other working groups to develop a
research project that assesses the
effectiveness of specific interven-
tions within TAHSN facilities.

THE FIRST 48 HOURS
To determine what practices for
preventing functional decline in
the elderly are currently being used,
members of the Elder Care Initiative

A community of
practice is developing
to foster scholarship
that informs hospital
care for elders
have an atypical presentation of an 
in the ACE Unit. “Older adults can 
diagnosis that landed the individual 
behaviour. 
decline in functional abilities, and/
problems that may include a recent 
admission and a variety of presenting 
designed for seniors with an acute 
patients. Mount Sinai’s ACE Unit is 
interprofessional team standing 
(ACE) Unit. These units have an 
into an Acute Care for Elders 
ward 
Acing it 
really shine.”

THE MOUNT SINAI ELDER CARE INITIATIVE 
Geriatric care improvements often start with one person – a nurse

“We wrap our arms around elder 
care,” says Tracy Kitch, MScN 9T1. 
“It’s an organizational commitment 
across the whole of Mount Sinai 
Hospital.”

In 2010, Mount Sinai became 
the first academic health sciences 
centre in Canada to make geriatrics 
a core strategic priority. Five years 
earlier, Jocelyn Bennett, MScN 9T1, 
initiated the process by working with 
a handful of physicians. “The writing 
was on the wall,” says Bennett, the 
senior director of urgent and critical 
care. “What we’re seeing is people 
living longer. The heart attack that 
might have ended a life at 72 has 
become heart failure at 83.” Today, 
one-third of all individuals admitted 
to Mount Sinai are over 65.

Bennett is quick to point out 
that nurses are leading the geriatric 
initiative. “It’s nurses who minimize 
falls, nurses who prevent delirium, 
nurses who teach families how to 
manage the effects of aging. Elder 
care is an area in which nurses can 
really shine.”

ACING IT
By 2011, Mount Sinai was converting 
a 28-bed general medicine ward 
into an Acute Care for Elders 
(ACE) Unit. These units have an 
interprofessional team standing 
ready to address the complex health 
and social care needs of older 
patients. Mount Sinai’s ACE Unit is 
designed for seniors with an acute 
admission and a variety of presenting 
problems that may include a recent 
decline in functional abilities, and/ 
or a recent change in cognition or 
behaviour.

The team starts by exploring the 
diagnosis that landed the individual 
in the ACE Unit. “Older adults can 
have an atypical presentation of an 
illness,” explains Bennett, who is 
also a Bloomberg adjunct faculty 
member. “A urinary tract infection, 
for example, may present as 
delirium. Good geriatric nurses tend 
to be good detectives.

“We do everything we can 
to minimize the hazards of 
hospitalization,” she continues. 
“Some people think that if you’re 
sick you should go to bed. But for 
every day a senior spends in bed, you 
can add two days to the length of the 
hospital stay. Seniors de-condition 
quickly, they’re just not as physically 
resilient as younger people.”

Patients on the 10th floor unit are 
encouraged to maintain or regain 
the independence they enjoyed 
prior to the admission. “We don’t 
impede mobility – no bedpans, 
when possible. And no catheters. 
We consider a catheter a one-point 
restraint,” says Bennett.

You might think that being 
encouraged to get out of bed and 
maybe walk down the hall might 
annoy a senior suffering from 
an acute illness. In fact, patient 
satisfaction rates couldn’t be better – 
almost 100 per cent of the unit’s 
patients report being satisfied with 
the care they received.

The majority are able to go home 
after their stay. “Almost 80 per 
cent of the ACE patients who live with 
a certain level of independence 
are able to return to their pre-
admission home,” says Bennett. 
Many Bloomberg students have the 
opportunity of learning these new 
strategies in elder care through 
clinical placements in the unit.

“Some of the magic around 
the ACE Unit is our talent,” adds 
Kitch, Mount Sinai’s executive vice-

sent a survey to all TAHSN affiliated 
sites. Twelve health care organizations 
responded, and nine of them reported 
having interventions in place.

“There is growing evidence that 
a multi-component intervention is 
essential to minimize functional 
decline,” says McGilton, “but there 
is a need to conduct further research 
on which components are most 
effective for which sub-groups. 
The collaboration of academics, 
clinicians and administrators is an 
important partnership from which 
to build, evaluate and sustain these 
interventions.”

Soon after sending out the survey, 
McGilton came across a report 
from the Vancouver Coastal Health 
Authority. “It’s an absolute gold mine,” 
she enthuses. “They’re doing an 
amazing job with elder care in B.C. 
And we can learn from their work; for 
example, how they have been able to 
build a community of practice focused 
on preventing functional decline with 
hundreds of staff in their region.”

The Report offers the “48/5 Rule for 
the Prevention of Functional Decline.”

It states that within 48 hours of 
hospital admission, care plans must be 
developed to address the needs of older 
patients in five key areas: delirium/ 
cognition, medications, functional 
mobility, nutrition/hydration and 
bowel/bladder.

“The next steps for the TAHSN/ 
U of T Elder Care Initiative may 
include developing and evaluating 
the protocols for interventions 
focused on these factors,” says 
McGilton. “The partnership between 
the University of Toronto and 
TAHSN community will act as 
a conduit for the exchange of 
innovations focused on improvement 
of elder care. Ultimately, clinical 
units that focus on the prevention of 
functional decline will serve as an 
exemplar clinical placement for U of T 
Nursing’s undergraduate and graduate 
students.”
Spotlight on Learning

AGING WITH DIGNITY

“I sought out Eileen Bourret,” says Shannon Farley, BScN 9T7, MN 1T3. “It’s worthwhile searching for a good preceptor, and Eileen came highly recommended.”

For eight years, Bourret has served as a preceptor to Bloomberg master’s students in the clinical field of study. She also lectures on senior care during the students’ residency week and assists with the objectively structured clinical examination (OSCE).

Bourret’s main job, though, is with Trillium Health Partners. At the Queensway Health Centre site in Etobicoke, she assesses patients in the geriatric ambulatory clinic. Clients often fear what the assessment might find, particularly if they’re experiencing memory problems. “Many people are more worried about dementia than any other illness, except maybe for cancer.

“Dementia is a diagnosis of exclusion,” continues Bourret, who earned an acute care nurse practitioner certificate at U of T Nursing in 9T5. During the initial assessment, which takes up to 1.5 hours, Bourret reviews everything from thyroid function to vitamin B12 levels. She also administers standardized cognitive tests.

When a graduate student first arrives at the placement, Bourret asks the nurse to observe. But it wasn’t long before Farley was sharing in the care, with Bourret offering lessons along the way.

LESSON #1

“Eileen showed me how to do an incredibly comprehensive patient assessment that includes a financial assessment, dietary assessment and an understanding of the client’s living environment,” says Farley, who practises at Juravinski Hospital in Hamilton.

The assessment culminates with a head-to-toe physical exam. “We check visual acuity and fields, and how the client is focusing,” says Farley. “We check hearing. We listen for bruits in the neck and abdomen. We take off the patient’s socks and look for ulcers. We watch the client walk as gait changes can precede cognitive decline, and noting them can improve early detection of dementia.”

On and on the two nurses would go, performing three or four assessments a day for the three-month placement. “My success in the OSCE is directly related to what I learned from Eileen,” says Farley.

LESSON #2

“There’s a tendency to talk to the family member if the patient is cognitively impaired,” cautions Bourret, who is also a Bloomberg adjunct faculty member. “It’s important to address the patient directly. I start out by asking the patient, ‘What is your understanding of why you’re here today?’ Later, I might tell the patient, ‘Now I’m going to ask your daughter if she has noticed any change.’”

“Eileen makes it clear that it’s a patient’s right to be treated with dignity and respect,” says Farley. “She taught me how to communicate with someone with dementia by making eye contact, using short sentences and asking only one question at a time.”

“Don’t give up on the older person,” instructs Bourret. “There’s a tendency to dismiss or devalue older people, particularly those with dementia.”

Interested in sharing your knowledge with graduate nursing students by becoming a preceptor? For more information, email mnplacements@utoronto.ca

Eileen Bourret (left) and Shannon Farley
**News**

**The Best Summer Job - Ever!**

It was a win-win situation. The Undergraduate Student Summer Research Program paired 22 Bloomberg undergrads with faculty members. The students got research experience and a summer job; the professors got 13 weeks of much-appreciated research support from this enthusiastic group of students.

Amanda Kerr from the Class of 1T4 helped Professor Kelly Metcalfe with the Rapid Genetic Testing Study. Dr. Metcalfe is evaluating whether testing for mutations in the BRCA1 and BRCA2 genes affects treatment decisions in newly diagnosed breast cancer patients. “If they have a tumor in one breast and carry these mutations, they’re at higher risk of developing a tumor in the other breast,” explains Kerr. New technology can provide genetic testing results in five to 10 business days, before the women need to decide on how extensive of a surgery to undergo.

“I’ve always been interested in research,” says Kerr, who contributed to an ovarian cancer investigation while earning her master’s in biomedical science. “This study has helped increase my patient interviewing skills because I’ve been meeting with patients face to face.”

If Kerr hadn’t been chosen from the 40 undergrads who applied for the program, she says. “If I couldn’t be a PSW, well maybe I would have been a Starbucks barista.”

**Awarding Talent**

The Canadian Institutes of Health Research has chosen Associate Professor Louise Rose to receive an esteemed New Investigator Award. Dr. Louise Rose is studying how to improve the experience of patients with long-term respiratory failure and prevent the complications associated with mechanical ventilation.

“Those requiring mechanical ventilation are some of the most vulnerable, fragile patients in the community,” says Louise Rose, who previously held the inaugural Bloomberg Limited-Tenure Professorship in Critical Care Nursing. “With the CIHR New Investigator Award, I can focus on conducting research to inform policy development and support best practices.”

If patients are kept on a breathing machine for longer than 21 days, they can develop infections or blood clots, or have a heart attack, explains Louise Rose. “The longer they’re on a ventilator, the more difficult it is to wean them off of it. These patients need to get out of the ICU and off the ventilator as soon as possible.

“Survey data from our research program has just come in, and it’s the first of its kind on prolonged mechanical ventilation in Canada,” she continues. “This data is helping us identify best practices which we need to implement in ICUs across Canada. And we need to start implementing them right now.”
Welcoming the world

Bloomberg Nursing is launching the Emerging Scholars Forum to give new nurse researchers the opportunity to network with their colleagues from around the world. The two-day event in late November will offer Canadian, American and international doctoral and post-doctoral students a venue in which to exchange ideas. Several of U of T Nursing’s doctoral students and junior faculty members will also participate.

“Our Emerging Nurse Scholars meeting is an initiative we launched a couple of years ago when we hosted a symposium for doctoral students and junior faculty,” says Linda McGillis Hall, the former associate dean of research and external relations who was recently appointed interim dean. “The Faculty is widely recognized as a research-intensive environment that promotes education and scholarship in nursing. This forum supports early career development along with the opportunity for building partnerships through international networking for scholars embarking on a research career.”

Attendance at the forum is by invitation only. A peer-review application process selected the forum delegates who received the additional honour of being asked to present their research. U of T Nursing faculty members will lead the discussion and speak on how to develop a successful academic career.

Spring Reunion 2013

In June, more than a hundred alumni came together at Bloomberg Nursing to reminisce, enjoy breakfast, tour our Nursing Simulation Lab and honour their fellow grads.

Members of the Class of 6T3 who attended the reunion each received a 50th anniversary pin. To commemorate this milestone anniversary, members have joined the Class of 6T2 in making a donation as a group of classmates. This new award will be used to further the translation of nursing knowledge into practice. “Class awards are very much a collaborative philanthropic effort,” says Suzanne Heft, assistant dean, advancement. “We are deeply grateful to the members of the Class of 6T2 and 6T3 for their generosity and for setting such a great example for others to follow.”

A highlight of each Spring Reunion is the presentation of the Distinguished Alumni Awards. These awards honour grads who have been recognized by their peers for making exceptional achievements in nursing and health care. Many of our alumni deserve to be commended for the outstanding contributions they’re making to our profession and to health care.

U of T Nursing is now seeking nominations for next year’s awards. To nominate an alumnus who has risen above the crowd or find out more about making a class gift, please contact alumni.nursing@utoronto.ca. For information on the Distinguished Alumni Awards, visit www.nursing.utoronto.ca/alumni/awards.htm

Distinguished Alumni Award winners 2013

Congratulations to this year’s award recipients!

Tracey DasGupta, BScN 9T1, MN 0T7, received the Distinguished Alumnus Award. DasGupta is the director of nursing practice and informatics at Sunnybrook Health Sciences Centre where she focuses on best practice implementation and leadership development.

Jenny Ploeg, PhD 9T9, also won a Distinguished Alumnus Award. Ploeg has been a principal investigator or co-investigator on 68 funded grants. She is a renowned mentor of graduate students as well as an advocate for services for the elderly living in the community.

Joy Richards, BScN 8T1, MN 0T0, was honoured with the Award of Distinction. Richards is vice-president health professions and chief nursing executive at University Health Network. Her doctoral dissertation focused on female courage among nurse leaders.

Gillian Strudwick, MN 1T1, received the Rising Star Award in Clinical and Community Nursing, which acknowledges an alumnus who has made significant contributions in these areas within 10 years of graduating with a baccalaureate in nursing. Strudwick, as an editorial reviewer, developed a national community of practice program to help nurses build capacity in vascular access. She has also contributed to several health initiatives in other countries, including Nepal, Peru and Kenya.
Our exemplary educators

Every autumn, U of T Nursing acknowledges some of its top educators with a teaching award. Among the 16 recognized this year were three preceptors.

In the Undergraduate category, Mishel Ajison was recognized for ensuring that the student she was precepting in the NUR 461 Primary Health Care Perspective course developed the skills and critical-thinking capacities crucial to community nursing. Ajison, who practises with VON, introduced the undergrad to the complexity and diversity in patient populations and home conditions, always sending him home with reading materials to supplement his knowledge and practice skills.

In the Graduate category, Nancy Marco, MN 079, was honoured for not only being a top preceptor, but for continuing to help students as they begin their career as a nurse practitioner. Marco serves on various committees and invited her students to join the meetings to develop their leadership skills and recognize their potential for making a difference.

Alina Shcharinsky, MN 11, also won in the Graduate category. Shcharinsky’s contributions include instilling confidence in the students she preceptored by offering a high level of support in her practice area: neurosurgery. Ever enthusiastic, she offered a variety of learning experiences in the placement, including attending epilepsy and neurology rounds.

Old friends making new friends at the Spring Reunion

Former Dean Sioban Nelson (left) with the 2013 Distinguished Alumni Award winners: Jenny Ploeg, Tracey DasGupta, Gillian Strudwick and Joy Richards
A CONVERSATION WITH SHIRLEE SHARKEY

The president and CEO of Saint Elizabeth Health Care shares the insights she gleaned from leading a provincial review of staffing in long-term care homes

**Pulse:** When you visited long-term care homes as part of the review, did anything surprise you?

**Sharkey:** I was impressed by the passion and commitment of the talent and staff in the homes. But I was surprised that so many of the residents didn’t want to be there. I had many conversations with seniors that started with, “How on earth did this happen? I don’t know how I ended up in this place. I was in my own apartment. I could get up and make myself a cup of tea and then – Bam! – I’m in this place.”

It was a huge change in lifestyle. Many had been hospitalized, and that tipped them going into a facility. Others just had never accepted – and I’m not sure they ever will accept – that this facility is where they live now.

Imagine if somebody suddenly said to you, “You’re not going home anymore, now you’ll be living in a home.” And without any transition – away you go. If that happened to me, I can only imagine how I would react.

**Pulse:** I imagine you would be extremely upset.

**Sharkey:** What I saw was despair. The seniors weren’t actually crying. While they were talking, the tears were just coming down their cheeks. And that tells me they had lost hope. To this day, that image haunts me. You don’t want to see anyone really unhappy when they don’t need to be.

The issue is loss of independence and control. They would say, “I don’t like getting up at 7 o’clock in the morning. I used to sleep in and watch a TV show and I can’t do that anymore. I just want to talk with someone, and another activity will be happening and we have to move and do something else.”

What the experience makes me think of is this – when you’re staying as a guest in someone’s home, there is a sense of anxiety about little things such as, should I get myself a coffee or should I wait for them to offer? It’s a feeling of being a little tense, despite the fact that they are delighted to have you. This uneasy feeling we feel as guests seems to me to be similar to what people moving to a long-term care home experience.

It’s sad that they are no longer comfortable in what is now their home.

**Pulse:** So we need more home care?

**Sharkey:** It’s an erroneous concept that if we get the location right, we’ll get the health care right. We’re preoccupied with location. Home care. Or retirement homes. Or long-term care facilities. Or the need to divert seniors from emergency rooms. It’s not about location. It’s about understanding the best evidence and best practices that give a better quality of life, a better use of resources.

**Pulse:** Did you find staffing adequate?

**Sharkey:** I thought there was a shortage overall. Nurses practising in long-term care experience many competing priorities so don’t have time to slow down, listen and really connect with the residents. Nurses have to listen very, very carefully to make assessments and determine what the issues are, and that takes time. I think we can do a lot of harm by rushing those exchanges.

**Pulse:** Are there any ratios we should be looking at?

**Sharkey:** About 80 per cent of the care provided to seniors in their homes and the community is by family, volunteers and neighbours.

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**Pulse:** Are there any ratios we should be looking at?

**Sharkey:** About 80 per cent of the care provided to seniors in their homes and the community is by family, volunteers and neighbours.
Only 20 per cent is provided by our health care system. So where would you put your resources – in the 80 per cent or the 20 per cent? The caregiver piece is hugely important. What we’re looking at now is how to help caregivers once they’ve burnt out. What we should be doing is putting more front-end resources into understanding and preventing caregiver burnout.

**Pulse:** Are you hopeful about the future of elder care?

**Sharkey:** There’s a significant gap from where we are now and where we could be, but I think the boomers will quickly close that gap. There will be new technology, innovations and opportunities, and a readiness for a new way of doing things. Some seniors say to me, “We’re ready for it dear, you’re just not ready for us.”

Beginning in 2007, Shirlee Sharkey, RN, spearheaded the People Caring for People review of staffing and care standards in Ontario’s long-term care homes. At U of T, the former RNAO president is cross-appointed to Bloomberg Nursing and the Institute of Health Policy, Management and Evaluation as an adjunct professor.
The Canadian population is aging, the nursing population is aging, and each of us is aging. All three scenarios present challenges. As a former gerontological nurse, educator and researcher who has now personally experienced aging, I can speak to two of these scenarios with some authority. An issue that confronts nursing education at all universities including the Bloomberg Faculty is how to educate all nurses to become competent in the care of older people because, with the exception of those entering perinatal and paediatric nursing, older people are who they will be caring for.

While aging extends throughout life, the transition from middle through old age is the focus of gerontology. Even though we have our lifetime to get ready for this transition, when the signs of normal aging begin to appear, they take most of us by surprise. The alternative to aging is to die young, but this reality provides little comfort when you look in a mirror and a wrinkled and much older version of the person you believe yourself to be stares back. How can that 27-year-old who lives in my body look like this?

It is even more alarming to realize that those wrinkles are one of the more benign features of aging. Compare them with a compromised memory for names and nouns when you need them, slowed reaction time, diminished hearing and less sharp vision, balance that no longer guarantees to keep you on your feet, and the onset of some chronic diseases that seem to spring from nowhere. The benefits of being old – such as being wiser, having better judgment about some things, and deriving more pleasure from family and friends – strain to offset the downside of getting old.

Being old is almost impossible to imagine until it is personally experienced. It is one thing to acquire the intellectual knowledge of what the aging process entails and how the body changes and why, and quite another to know what the loss of capacity feels like. Nurses and other health care providers won’t experience the most discomfiting consequences of aging until after they have retired from their working lives. So nurses must not only acquire the intellectual knowledge but also listen carefully to the older persons who depend on them to get as realistic a feel as possible for what older persons experience. To be a competent gerontological nurse, you require an understanding, indeed a deep knowledge, of the many dimensions of the normal aging process and the changes they bring to the body and brain. This is the challenge for nursing education and nursing practice but it is a challenge we are increasingly meeting.

In my view, one of the greatest challenges for gerontological nursing is to make residential long-term care a destination not associated with fear and dread but one that promises and delivers comfort, caring and pleasurable daily lives. There are some excellent nursing homes that combine the best of nursing care with equal attention to the quality of the daily lives of the residents but, unfortunately, these homes continue to be the exception. This is nursing’s problem to solve.

One of the realities of nursing education is that few students enter nursing with an interest in caring for older people. The best way to overcome this is for students to work with faculty members and clinical preceptors with expertise and a passion for caring for older people and who can inspire and convince students that gerontology is a wonderfully challenging and rewarding specialty.

As a result of research conducted by nurses and members of other disciplines, there have been many gains in understanding how we age, what it means to age and effective ways of caring for older people in all parts of the health care system. Researchers at our Faculty have made important contributions to this pool of knowledge, but we must continue to attract our outstanding nursing students into gerontological nursing in order to prepare the researchers of the future. It’s a tall order, but an achievable one.
**Course: Preparing to Write the CRNE**

In this two-day Canadian Registered Nurse Exam (CRNE) preparation course, you review the exam structure and study approaches to answering multiple-choice questions. You 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 U of T Nursing Centre for Professional Development course will also be offered in April in Toronto and Edmonton.

**To learn more and register:**
www.bloomberg.nursing.utoronto.ca/pd

**Course: Advanced Health Assessment and Clinical Reasoning for NPs**

This seven-week Centre for Professional Development course offers a focused review of advanced nursing practice using the Canadian Nurse Practitioner Core Competency Framework. The clinical reasoning and decision-making skills required in a primary health care setting will be emphasized. To facilitate the participation of learners throughout Ontario, this course will be offered online.

**To learn more and register:**
www.bloomberg.nursing.utoronto.ca/pd

**Course: 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 Centre for Professional Development course, the faculty members highlight the scholarship and the art that support successful, creative clinical teaching.

**To learn more and register:**
www.bloomberg.nursing.utoronto.ca/pd

**Course: National Institute on Nursing Informatics**

Assistant Professor Lynn Nagle will lead this Centre for Professional Development program that provides 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. The Institute will be preceded by five webinars, which are included in the registration for the program. To ensure a focused experience, registration is limited.

**To learn more and register:**
www.bloomberg.nursing.utoronto.ca/pd

**Course: Institute on Nursing Ethics**

Learn how to effectively integrate ethics into everyday practice by recognizing and addressing issues. In this two-day Centre for Professional Development course, you learn strategies to facilitate discussions with patients, family members and colleagues, and increase your awareness of the relationship between personal, professional and organizational values within the context of care.

**To learn more and register:**
www.bloomberg.nursing.utoronto.ca/pd

**Course: OSCE Simulations for NPs**

Learn how to prepare for objective standardized comprehensive evaluation (OSCE) practice assessments. This one-day Centre for Professional Development course builds your knowledge and confidence for taking these rigorous evaluations.

**To learn more and register:**
www.bloomberg.nursing.utoronto.ca/pd

**Spring Reunion**

Bloomberg Nursing will host a breakfast, present the Distinguished Alumni Awards and provide tours of the Nursing Simulation Lab. Everyone is invited, and you’ll be an honoured guest if you graduated in a year ending in 4 or 9; for example, 1964 or 1999.

**For help with organizing a class reunion:** Email alumni.nursing@utoronto.ca or phone 416.946.8165
The Rockefeller Foundation in New York City proudly displays this 1939 photograph of U of T nursing graduates on the special website it created to celebrate its centenary. The grads had just completed an innovative three-year program that received pivotal funding from John D. Rockefeller Sr. It was the first nursing program in Canada to be independent from a hospital; our teachers even maintained student control in the hospitals. In another initiative, the oil tycoon sponsored nurses from around the world to study public health nursing and education, and many of these “Rockefeller fellows” came to study at our school.

In 1913, the philanthropist founded the Rockefeller Foundation to “promote the well-being of humanity.” The powerhouse foundation boosted worldwide agriculture production, developed a vaccine for yellow fever and made strides in combating malaria. It also helped globalize public health nursing and nursing education.

Between 1924 and 1955, U of T Nursing educated hundreds of Rockefeller nursing fellows. While an exact figure is hard to nail down, it’s estimated that our school educated up to 50 per cent of these fellows over the course of their North American stay. Typically, a fellow would come for one year to study public health nursing, education or administration, but some came for a special summer course on leadership.

To find Rockefeller fellows, the foundation scanned 70 countries for nurses with leadership talent. And leaders are exactly what many became. Among those who studied at U of T Nursing was Ruth Nita Barrow from Barbados. Barrow went onto oversee the development of public health nursing in Jamaica and eventually became the governor general of Barbados. When Eugenia Costes graduated from U of T Nursing in 1928, she returned to Romania and founded the Romanian Nurses Association.

By globalizing public health nursing and nursing education, the foundation brought the benefits of modern science, education and medicine to countless countries. Rockefeller, though, maintained his rugged good health with homeopathy.
Joy Richards, BScN 8T1, MN OT0, received the 2013 Distinguished Alumnus Award. She is the Vice-President of Health Professions and Chief Nursing Executive at University Health Network in Toronto.
Lead practice change. Be an innovator.

The Centre for Professional Development is U of T Nursing’s hub for innovative and advanced learning opportunities. Delivered by exemplary professionals and professors, the Centre’s programs feature the same rigorous standards – and the same outstanding results – as our academic programs.

Upcoming Courses

Preparing to Write the CRNE
January 11 and 12

The Foundations and Scholarship of Clinical Teaching
January 28 and 29

National Institute on Nursing Informatics
February 21, 22 and 23

Advanced Health Assessment and Clinical Reasoning for Nurse Practitioners
Spring 2014

Nursing Ethics
Spring 2014

OSCE Simulations for Nurse Practitioners – A Preparatory Course
Spring 2014

For information on upcoming programs, refer to Events on page 27 or visit www.bloomberg.nursing.utoronto.ca/pd

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