Nurses See the Irony in Study Touting Benefits of RN Care

Ontario Nurses’ Association (ONA) members must be forgiven if they found a recent report on the benefits of RN care for pediatric patients suffering from asthma (source) ironic.

Written by Ottawa Citizen reporter Andrew Duffy, the report notes that a new study by a Children’s Hospital of Eastern Ontario (CHEO) pediatrician found what registered nurses know and countless other studies have shown: RN care is beneficial to patients and improves health outcomes.

The report notes that the results of the study, showing that RN care for patients with severe asthma results in pediatric patients being able to be discharged from hospital more quickly and healthier, were so convincing that CHEO has immediately changed its system to implement the RN care.

Dr. Catherine Pound’s study showed that the nurse-driven system cut the average length of stay for pediatric asthma patients by 18 per cent.

ONA notes in a letter to the editor (source) that CHEO cut RN care last year, eliminating 49 RN positions.

Ironic that it is now promoting the benefits of RN care, including improved efficiency, streamlined patient management systems and no compromise to the quality of care.

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What is ONA?
The Ontario Nurses’ Association (ONA) is the union representing 62,000 registered nurses and allied health professionals and more than 16,000 nursing student affiliates providing care in Ontario hospitals, long-term care facilities, public health, the community, clinics and industry.

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Who is Linda Haslam-Stroud, RN?
ONA President Linda Haslam-Stroud, RN (pictured), is a veteran renal transplant nurse who is an expert spokesperson on a range of issues. Linda is available to comment on everything from workplace violence, patient care, health care policy in Ontario, the flu pandemic, nursing cuts, public health and much more. Simply contact ONA’s media relations officer, Sheree Bond, at (416) 964-8833, ext. 2430 if you would like to interview Linda on a health-related issue.

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Workplace Violence Continues to Make the News

Violence in the workplace – especially in health care – continues to be covered in the media on a regular basis.

The Windsor Star’s Brian Cross (source) recently reported on a registered practical nurse who says she is looking forward to returning to work at Windsor Regional Hospital, despite an incident in which a patient choked her.

Hospital CEO David Musyj said the incident was the worst level of violence since he began there – nearly 20 years ago – and reflects the rise in violence in hospitals and health-care institutions across the country.

The report quotes ONA Bargaining Unit President Donna MacInnes as saying that violence “does happen on a daily basis.” ONA First Vice-President Vicki McKenna also commented, saying that an ad campaign to end workplace violence has been launched by ONA. She notes that research shows that many violent attacks on nurses go unreported and an action plan from the government is needed.

Musyj said two factors in the increase in the number and severity of the attacks are patients coping with mental health issues and the drug epidemic. However, McKenna said that in many cases, the increase in violence is caused by understaffing.

She told Cross that “you have to staff based on what patients need, not the mathematical equation.”

Interestingly, Windsor Regional Hospital cut 169 registered nurses from its hospital last year.
Little Agreement on How to Cut Workplace Violence

In the U.S., the journal *Modern Healthcare* ([source](#)) has published an in-depth article on the issue of how to quell violence in health care settings.

It notes that violent incidents in health-care settings have steadily risen in recent years and are taking a “growing financial and human toll” on health-care workers. Despite the concerns, in the U.S., there is little agreement on how to address violence. The report notes that hospitals have debuted technologies and launched awareness campaigns, states have proposed legislation requiring workplaces to establish anti-violence protocols and unions have pushed for minimum nurse-to-patient ratios.

California Nurses Association-National Nurses United director of health and safety, Bonnie Castillo, RN, says part of the problem is knowing when an incident is likely to happen. “You can’t predict when they’re going to happen, but you know they are going to happen,” she said.

Interestingly to ONA members, the report discusses the impact of the nursing shortage and “skeletal” staffing levels on the level of violence. The report says that when nurse-to-patient ratios fall below a critical level, the risk of violence increases. Nurse and associate professor at the University of the Cincinnati College of Nursing Gordon Gillespie says that violence can even be a tool patients use to catch a nurse’s attention when understaffing occurs.

ONA agrees with the report’s note that “it is the time that nurses are spending with [patients] that’s allowing them to assess the degree to which the behavior they’re seeing could be problematic. If there’s not sufficient staffing, that’s a missed opportunity to catch something before it’s a problem.”

ONA has been on the front lines of the war against not only workplace violence but disruptive physician behavior. Here, ONA First Vice-President Vicki McKenna talks to CBC News about the issue.

Michele Mandel’s recent *Toronto Sun* report ([source](#)) – on the failure of the Ontario College of Physicians and Surgeons to alert patients to the fact that a cardiologist has lost his hospital privileges due to obsession with an RN coworker – misses a major point.

Mandel writes about a prominent cardiologist, Dr. Milan Gupta, who began stalking an RN who worked with him in a catheterization lab. The behavior began in 2010 and it took until earlier this year for his hospital – William Osler Health System – to successfully revoke his privileges.

The *Sun* report notes that Gupta had several chances to preserve his privileges, but after multiple suspensions he continued to cyberstalk the ONA member, inappropriately accessing her health records 29 times.

There are similarities between this case and the case of Lori Dupont, RN, who was stabbed to death in 2005 while working at Hotel-Dieu Grace Hospital in Windsor. She, too, had been stalked by a physician coworker. Despite complaints by Dupont and her RN colleagues, the hospital failed to revoke her attacker’s privileges.

The real issue in the case of Lori Dupont was that it was virtually impossible for a hospital to revoke physician privileges, no matter how egregious the behavior. Here we are, 12 years later, and that remains true.

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Sunshine List Ignores the Meaning Behind RN Salaries

Each year, media coverage in Ontario of the release of the annual Sunshine List of public-sector salaries notes the number of registered nurses who were paid more than $100,000.

Readers and reporters may conclude that that level of salary is the norm for the province’s RNs, as the figures do not distinguish between the base salaries of registered nurses and that earned from working massive amounts of overtime.

Ontario hospital RNs are paid an hourly wage of $32.21 at the start of their nursing careers. For a full-time RN, this means an annual salary of $62,809. When an RN obtains a full 25 years of nursing experience, the maximum hourly salary is $46.11 or $89,914 a year – a decent amount for many Ontarians but not overpaid when one considers the four years of university required to become a licensed RN and the ongoing education and certifications required.

Reporters looking in their communities who see dozens of RNs on the Sunshine List – such as in Windsor, Ontario – should recognize that these RNs are working many, many hours of overtime to break the Sunshine List barrier.

Interestingly, in Windsor there are a number of RNs on the Sunshine List from Windsor Regional Hospital (source) where, just more than a year ago, drastic RN cuts were announced. In January, 2015, CEO David Musyj announced that 169 RN positions would be cut and half replaced by RPNs. The Windsor Star report notes that the number of RNs on the list jumped from 97 in 2015 to 147 last year.

Reporters should do a little investigating when they see a large number of RNs on the Sunshine List in their community. It likely means that the nurses are working a great deal of overtime, and perhaps the facility needs to stop cutting RN positions and hire enough nurses to meet the patient care needs.
Payne describes the reality of an overcapacity hospital from the ground level, from the perspectives of patients and their families, nurses, physicians and management.

Payne visited the hospital during March break, when many were abroad. While noting that the streets of Ottawa were quieter than normal, inside the Queensway Carleton Hospital's ER, it was “already a traffic jam.”

The hospital’s situation goes from 105 per cent full – or Level 3 at 9 a.m. to Level 4 by the end of the day.

Throughout the day, reports Payne, the hospital sends pages asking staff to consider discharging patients “if appropriate and safe” to make room to admit those in the ER.

During Payne’s visit, there was a “stomach bug” that had been hitting nursing staff, making staffing a challenge right when nurses were needed the most.

Payne writes that while winter brings more patients with flu and respiratory illnesses to the ER, the issue of overcapacity hospitals reflects the growing demographic of aging baby boomers. She notes that some hospitals have reached the point where “they are seldom, if ever, at or below 100 per cent capacity.”

As *Behind the Front Lines* has reported before, the ideal capacity level for a hospital is approximately 85 per cent. This ensures there is “surge capacity” available should there be a disaster or a sudden influx of patients.

In the Ottawa area, Queensway Carleton Hospital has 264 beds, “significantly smaller” than The Ottawa Hospital with 1,050 beds and a proximity to long-term care and retirement homes, bringing a high volume of elderly patients.

Kudos to Payne for her reporting on the impact on staff.

The hospital’s clinical care coordinator for the ER, Jaclyn Drynan, is quoted on the need for nurses and other staff to “think fast. There are many nurses working very hard and doing very well and patient safety is their first thought, but it is a lot more exhausting and taxing on the nurses,” she told Payne. “I know there are days when they leave that they wish they could have done more [such as] spending more time with a patient to really make that connection. When you are just running from patient to patient, that is certainly a challenge.”

Triage nurse Meegan Smith describes her desire to “treat every patient like we would want our families to be treated,” and to maintain a sense of calm and order. However, when the hospital is over-capacity it is difficult to do so. Overcapacity “means the emergency department has admitted patients and emergency nurses are caring for them because there is no room on the units. That means less room and fewer staff to emergency departments.”

The other impact of being overcapacity is compromised safety.

Payne interviews physician Gordon Kee. “It is not just people’s hurt feelings,” he said. “They are out there with pneumonia and they are getting worse because they are not on antibiotics, they are not getting treated. That is happening.”

The reality of hospital care – after its years of funding freezes – can be summed up by the remarks of Karen Lemay, a care facilitator. “Many days, the emergency department doesn’t meet its standard of care – as spelled out in the Canadian Triage and Acuity Scale – because of overcrowding.”
**Nurse-Artist Profiled**

It was refreshing for ONA members to see a story about a registered nurse that wasn’t related to burn-out, a violent assault or the loss of a job.

The Toronto Star (source) recently profiled veteran RN Tilda Shalof and her love of creating art out of disposed hospital supplies.

Shalof worked as an intensive care unit nurse at Toronto General Hospital for 28 years, during which she collected bits of plastic that were disposed of during medical procedures. While emphasizing that the plastic never touched patients and was sterile – after all, she is a nurse – Shalof described how she saw the beauty in the colours of the pieces.

After leaving her job as an ICU nurse to work in a slower-paced, less stressful environment at Toronto Western Hospital, Shalof donated the work of art she had created with the disposable plastic bits to Toronto General.

The mosaic she created of more than 10,000 of the pieces, embedded in clear resin, measures 1.2 metres high by 2.7 metres long, and is now featured in the hospital.

Shalof, sounding every inch a nurse, says she hopes the art “provides both comfort and inspiration to hospital staff and patients,” reports the Star.

“For nurses, I think it shows that all the little things that we do every day add up to big things for each person we treat,” she is quoted as saying. “I couldn’t let them go,” she says of the plastic. “Each was like a talisman of all those people I had cared for. It’s a tribute to nursing.”

Most touching to nurses is her comment that “when you are creating, you feel empowered… It takes you out of the sadness of your work. Instead, it reminds you of the incredible work that we do.”

As Nursing Week approaches across Canada – May 8 to 12 – this is the kind of refreshing, unexpected and touching story ONA members hope gets more coverage.
Behind the Front Lines

Nuns Intuitively Speak More Skillfully to Ill Seniors

There is a fascinating story from Thomson Reuters (source) that may have implications for RN training for those working in long-term care.

A study by a linguistic anthropologist in California has found that nuns who act as care providers for other nuns rarely use “elderspeak” – a “loud, simple patronizing and common form of baby talk for seniors” that has been found to send the message that patients aren’t competent.

Published in the journal The Gerontologist, Anna Corwin’s study found that caregiving nuns ministering to their elders who suffered from dementia, Alzheimer’s disease, aphasia, stroke and neurological deterioration, instinctively avoided communicating in elderspeak.

Corwin says the nuns intuitively “accept decline. They value a person in a sort of inherent way.”

Nursing Professor Kristine Williams of the University of Kansas says that she trains nursing home nurses to use less elderspeak, and her own research found that this sort of training can make a difference.

Need a reliable and informed source? Speak to front-line nurses!

The Ontario Nurses’ Association has a whole host of experts in health care.ONA members work in hospitals, long-term care, public health, the community and industry and can answer your questions as health care continues to evolve in this province.

Contact ONA.

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