APPENDIX 1: RNAO Fellowships

Complex and Chronic Pain in a Paediatric Population

Fellow: Mary MacNeil, Children's Hospital of Eastern Ontario

Mentors: Jacqueline Ellis, University of Ottawa, Janice Cohen, Children's Hospital of Eastern Ontario & Margot Thomas, Children's Hospital of Eastern Ontario

A number of activities at the Children's Hospital of Eastern Ontario (CHEO) have been initiated to improve pain management. Out of these activities, a gap in service was identified with respect to complex and chronic pain. Data on the incidence of children suffering with complex and chronic pain in Eastern Ontario is not available. A Position Statement by the American Pain Society conservatively estimates that chronic pain affects 15% to 20% of children (2003). The most common causes of chronic pain in children are related to chronic disease (e.g. cancer, juvenile, rheumatoid arthritis, sickle cell, fibromyalgia), trauma (complex regional pain syndromes I and II, phantom limb pain), recurrent pain syndromes (e.g. migraines, abdominal pain, limb pain) and non-specific pain (e.g. knee, back pain and dysmenorrhea) (McGrath, 1999).

In partnership with the Registered Nurses Association of Ontario and CHEO, an Advanced Clinical/Practice Fellowship was provided to learn more about complex and chronic paediatric pain and suggest ways CHEO could improve care to this population. Some of the major accomplishments of this Fellowship include:

• Synthesized literature to extract information relevant to CHEO.
• Interviewed children and their families to get they’re perspective on coping with complex and/or chronic pain.
• Developed an Epidural Resource Kit for use by Nursing Staff in the Intensive Care Unit.
• Described and evaluated existing services at CHEO for managing children with complex and chronic pain.
• Described chronic pain service from a health services delivery perspective.
• Site visits to the Pain Services at the Toronto Hospital for Sick Children (HSC), IWK Health Centre, and Montreal Children’s Hospital (MCH) who were outstanding in their teaching and role modelling of effective pain management strategies.
• Participated in clinical practice days related to the following topics: pathophysiology of pain, epidural pain management, pain management in palliative care, child and family coping strategies, treatment strategies for acute and chronic pain, strategies to facilitate transition from paediatric to adult care, and function of multidisciplinary pain teams.
• Gained advocacy skills to support bedside nurses in advocating for effective pain management.
• Developed presentations related to complex and chronic paediatric pain for CHEO colleagues and also for a national nursing conference.

Benefits from the Fellowship experience will be ongoing as I advocate for effective pain management within the paediatric intensive care unit, among the pain resource nurses, and as a member of a newly established quality improvement team. This team will address services at CHEO for children with complex, chronic and recurrent pain.

I have also grown professionally during the Fellowship. I realize the importance of nursing education, in effectively managing pain but also appreciate that knowledge alone is not sufficient to change practice. For best practice pain management, an institutional commitment is required. The Fellowship has helped me understand the role of advanced practice nurses and the role of interdisciplinary, integrated pain teams in supporting and advocating for an organizational commitment to effective pain relief.

The Fellowship has been a wonderful learning opportunity that has served to further my commitment to advocating for effective pain relief at CHEO. Sincere thanks are extended to the Registered Nurses
Association of Ontario, administrative staff and nursing colleagues at CHEO, members of the pain teams at HSC, IWK, and MCH and last by not least, my mentors.

“Let us now be content to wait and see what will happen, but give us the determination to make the right things happen.”

References

Development of a Program for the Pediatric Cardiac Population Receiving Oral Anticoagulation

Fellow: Lynne Lynch, Children's Hospital of Eastern Ontario

Mentors: Judy Rashotte, Children's Hospital of Eastern Ontario & Debbie Hogan, Children's Hospital of Eastern Ontario

This fellowship provided a powerful experience. During the past 12 weeks, I have benefited from numerous learning opportunities. Although vigorous at times, my schedule reflected my learning plan, which I used as a tool to measure my progress.

My learning, obtained through a variety of strategies, was vast and diverse. The following are just but a few examples of what I learned and how I learned through this advanced clinical/practice fellowship program:

- A contribution to improving my communication skills was to observe a member of senior management (highly skilled in the role of chairperson) leading a committee meeting. A question period and thought exchange related to the art of being chairperson was also part of this learning opportunity and helped to highlight reflections I had made.
- This 12-week period has also given me the opportunity to access education online for the first time. I am currently enrolled in an online Microsoft Access course that is contributing to my knowledge of database management.
- The importance of being independent and being able to work in a self-directed fashion became apparent early in the fellowship experience and these are necessary skills to bring about positive and timely results.
- This fellowship has provided me the opportunity to become actively involved within the organization in a different role, as well as establish working relationships that will continue to grow. This unique opportunity enabled me to establish a networking system involving cardiology nurses from other Canadian Pediatric Cardiac Centers. This networking was achieved using a questionnaire to gather information about their anticoagulation service and practice.
- This learning experience has contributed to my personal and professional growth, stimulated my critical/creative thinking, and increased my awareness of what I do and how I do it. I have also improved and refined some communication skills, which has facilitated the dissemination of information with other pediatric health-care services, as well as the population for whom I care.

I would like to take this opportunity in sharing with you how grateful I am to have been able to participate in the Advanced Clinical/Practice Fellowship Program. I hope that many others nurses will be able to have the same opportunity in the future.

Bereavement Needs of Families Following a Paediatric Death
**Fellow:** Susan Porterfield, Children's Hospital of Eastern Ontario  

**Mentors:** Frances Fothergill-Bourbonnais, University of Ottawa, Marion Rattray, Children's Hospital of Eastern Ontario, Michelle Mullen, Children's Hospital of Eastern Ontario

In August 2003, I started a 12-week journey of learning. This RNAO Fellowship and the Children's Hospital of Eastern Ontario have provided me with an opportunity to increase my knowledge of the bereavement needs of families, children and of pediatric palliative care.

The literature review and readings continued throughout the fellowship and provided a base for further study and ongoing projects. By consulting with various palliative care programs I was able to compile a list of references and resources. This list contains a wealth of knowledge and provides a focus for continued learning. Some identical resources were identified by each group, and I consider them foundation resources for my further development and learning.

My site visits provided valuable learning experiences. The ability to view diverse pediatric palliative care programs and the opportunity to dialogue with experts in the field, has contributed to my knowledge of pediatric palliative care. This process of observing and discussion was validated by each group as being an important step in program development. The contacts and relationships I was able to develop during this Fellowship will continue throughout my career. During my site visits, I also explored the roles and responsibilities of the Advance Practice Nurse working in palliative care and with families. Through discussions and shadowing of practice I now have a better understanding of the Advance Practice Nurse’s role and how it can be incorporated into our Palliative Care Program.

My discussions with my mentors expanded, challenged, supported and guided my thought process and learning experience. My mentors provided a wealth of knowledge and experience in both adult and pediatric palliative care. They have helped me to understand the history, future and political aspects of palliative care. I have shared my knowledge with colleagues through many informal discussions, bi-weekly information sessions with the palliative care team and collaboration on a policy for bereavement follow-up. My future plans include presenting at Nursing Rounds and to the Clinical Educators and providing education sessions for the Bereavement Follow-up Program. I am also currently involved in the process of developing a Pediatric Hospice associated with the Children's Hospital of Eastern Ontario that will include bereavement programs for families and children. The knowledge and experience I have obtained in my RNAO fellowship will be instrumental in guiding the development of the hospice.

Key deliverables for my organization are the new Bereavement Follow-up policy, the revised Care of the Body After Death procedure, the completion of the Palliative Care Resource Binder and the new Hospice on Wheels. My site visits have also contributed to the organization. I have compiled a list from my colleagues at the different pediatric sites of their top resources and, I have also received from IWK a list of written resources for parents that they have compiled and critiqued. The HSC have shared their documentation records, pamphlets and resource material to help us develop some as well. The resources received from my site visits have been invaluable.

The RNAO Fellowship has contributed to my professional growth and strengthened my knowledge and credibility in the field of pediatric palliative care and bereavement. I would like to extend my appreciation to my mentors, all my colleagues and the nurses who facilitated my site visits. Lastly I would also like to thank RNAO, the Children’s Hospital of Eastern Ontario and the Ministry of Health and Long-Term Care for providing this wonderful learning opportunity.

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**Building Bridges: An Educational Model for Paediatric Critical Care**

**Fellow:** Trish Anderson, Kingston General Hospital  

**Mentor:** Margot Thomas, Children's Hospital of Eastern Ontario

Kingston General Hospital (KGH) has a 24-bed general pediatric unit that includes a 4-bed intermediate care unit. Children requiring intensive monitoring and/or mechanical ventilation are accommodated in the
Intensive Care Unit (ICU) wherein the population is typically adult in nature. Using a consultative model, nursing personnel from the ICU work in conjunction with nursing personnel from the pediatric unit to provide the necessary pediatric critical nursing care. While the philosophy of this approach is logical, the realities of the clinical settings do not always permit its being operationalized.

Additionally, maintaining pediatric critical nursing care competency presents a challenge in that the number of pediatric critically ill patients is relatively small. Mindful of these issues, my RNAO Fellowship focused on the creation of a pediatric critical care educational program including the identification of the necessary competencies required by staff from the general pediatric unit to more comfortably practice in an intensive care setting. Implementation and evaluation of one of the proposed modules from the newly created education program was also planned. The complexity of creating a program that considers the needs of adult learners, and in particular critical care nurses, as well as the specific needs of KGH, quickly became apparent.

An initial step began with exploration of the literature regarding principles, models, and theories on education and educational programs. While this phase evidenced many different theories and models for education, there was minimal literature specifically related to adult learners who are nurses in a pediatric critical care setting. However, general key principles for an educational program were identified. These included use of a didactic approach in combination with case studies and interactive learning. Assessment of learning needs, and an evaluative component was also acknowledged.

As the Fellowship journey continued, that which was learned from the literature review was combined with information gained from linking with clinical experts allowing me to begin creation of the program. Site visits were conducted to meet with critical care educators at the Children’s Hospital of Eastern Ontario; the Children’s Hospital of Western Ontario; and The Hospital for Sick Children. Each educator was able to offer support, guidance and information related to their style of teaching, relevant content, and strategies to face the challenges inherent in critical care education. The visits also allowed me to witness the care provided to critically ill patients in dedicated pediatric units, strengthening my knowledge related to disease processes and the specific pediatric nursing care required. Through these interactions I was able to identify approaches and topics for incorporation into my educational program, as well as new ways to manage routine clinical issues.

This opportunity provided by the RNAO Fellowship has been a personal and professional journey. I have been able to enhance my own competencies related to care of critically ill pediatric patients and their families. The experience has facilitated a connection to other teaching centers and educators within the province who continue to be resources and role models. Although this particular phase has been time limited, the journey for me as an educator continues as I plan further development, implementation, and evaluation of the now-established competencies for pediatric critical care education at KGH.

**Developing Evidence-Based Nursing Standards of Preventative Skin Care Learning Plan**

**Fellow:** Melanie Archambault, Children’s Hospital of Eastern Ontario

**Mentors:** Debbie Hogan, Children’s Hospital of Eastern Ontario, Diane Gregoire, Children’s Hospital of Eastern Ontario, Linda Boisvert, McGill University Centre

This RNAO Advanced Clinical Practice Fellowship was entirely dedicated to increase evidence-based knowledge about preventative neonatal skin care practices in order to further develop expertise amongst neonatal nurses in the NICU at CHEO. Also, strategies to 1) disseminate the skin breakdown prevention guideline (developed throughout the Fellowship) 2) to promote practitioner uptake of the changes in practice and 3) a plan to both implement these strategies and evaluate practitioner, client and organizational outcomes where explored.

The Children’s Hospital of Eastern Ontario (CHEO) was strongly supportive of this ACPF fellowship. CHEO NICU is a 20 bed Level III nursery. To date, skin care best practice guidelines have not been used in the NICU. Skin care is considered to be a crucial component of our nursing care and the need for guidelines (and further translation into policies and procedures) is believed to be pressing at a corporate level.
Because of the immature skin structures and the critical health issues encountered by infants in the neonatal intensive care unit (NICU), maintaining the protective functions of the skin becomes crucial to their health and well being. The skin is one of the largest organs of the body (McGurk & al. 2004). For infants, it makes up for 13% of total body weight compared to 3% of an adult’s body weight (Huffenes & Logsdon, 1997). The skin is a crucial component in the healing process because it is the interactive boundary of the patient. As nurses, we create an environment that is conductive to the healing process. Therefore, the care of the skin is viewed as a nursing responsibility for maintaining the patient’s health and promoting recovery in a nurturing environment (Lott & Hoath, 1998). As skin breakdown is unanimously thought to be correlated to increased morbidity in critically ill infants, providing the most current evidence-based preventative skin care is an essential component of holistic nursing care. It is also in accord with CHEO’s established philosophy that fosters high quality of care to the infants and children of Eastern Ontario, Western Quebec, Baffin Island and other referral regions.

The skin breakdown prevention guidelines describe and summarize the latest evidence about neonatal prophylactic / preventative skin care: 1) Skin Assessment, 2) Skin Breakdown Risk Assessment, 3) The first bath, 4) Bathing, 5) Umbilical Cord Care, 6) Emollients, 7) Nutritional Status, 8) Limit contact of skin with urine and feces, 9) reduce injury related to adhesives, 10) Reduce the risks of pressure injury 11) Reduce friction & shear, 12) Minimise the risk of skin IV infiltration and/or extravasation, 13) Prevent thermal injury and 14) Prevent chemical injury. These skin care guidelines are the first building blocks to effective skin care and aim to prevent pain and discomfort related to skin breakdown, infection and trauma. Even though skin care is viewed as a nursing responsibility, successful skin care really is a multidisciplinary team endeavour, which only reflects the complexity and the vital aspect of this organ.

The lack of consensus on various aspects of neonatal skin care makes evidence-based standards of care difficult to determine, and strongly indicates the need for a complete systematic review of these specific aspects of skin care. This review would identify the gaps in the literature, allowing further research to target the needs of the neonatal population more precisely. The neonatal skin care guidelines detailed in this document identify best practice according to our current knowledge; based on this preliminary review of the literature and expert opinions (CHEO’s NICU committee). The recommendations have been determined by group consensus in the NICU committee. These recommendations aim to create the safest environment possible for our infants, do no harm and provide high quality of care to all infants.

Breastfeeding the hospitalised child; developing clinical nursing expertise, comprehensive and coordinated nursing support of the breastfed infant and mother.

Fellow: Coralee Boileau, Children’s Hospital of Eastern Ontario

Mentors: Susan Lepine, Children’s Hospital of Eastern Ontario, Melissa Dougherty, Children’s Hospital of Eastern Ontario and Edith Kernerman, North York General Hospital

As an RN on the pediatric medical unit at the Children’s Hospital of Eastern Ontario I have cared for many breastfeeding families but was interested in providing greater support to the mothers and babies I encountered. My RNAO advanced clinical fellowship was an experience far greater than I had imagined it would be. It was focused on directly improving my knowledge at a clinical level of breastfeeding support for our families as well as establishing a framework for support throughout the hospital.

Over the course of the fellowship, I was able to network with a multitude of lactation specialists in and around the Ottawa area, as well as in the United States. Through site visits to most Ottawa based birthing hospitals, two Toronto based breastfeeding support clinics and the Children's Hospital of Philadelphia I gained great clinical experience on best practice breastfeeding support of well and hospitalized children. A site visit with public health allowed me the opportunity to understand followup for patients post discharge and available services to support a family's breastfeeding at home.

My site visit objectives included clinical techniques of evaluation and support of breastfeeding. As well, use and effectiveness of assessment tools in the area’s daily practice, existence of breastfeeding hospital policy and use of discharge packages were explored. Because the settings varied from clinic to well baby to sick children hospitals I also focused on program management such as patient population at the particular site,
demand for the service and affect of the program on their patient outcomes. I collected the various lactation consultants' information on merits and barriers to successful breastfeeding to be used in my in-service planning. This information allowed me to augment the theoretical knowledge gained during the first weeks of the fellowship through research and completion of the Perinatal Partnership Program of Eastern and Southeastern Ontario (PPPES0) 18 hour breastfeeding management course.

This global gathering of information allowed me to create tools that are directed to our specific focus of care for breastfeeding patients which include: A hospital breastfeeding policy, a "LATCH" pocket assessment tool for nurses, a summary sheet of community breastfeeding support, a breastfeeding decision tree, a breastfeeding support program availability comparison chart, a pumping log, a breastfeeding basics pamphlet for families, an in-service for nursing staff on the key elements to effective breastfeeding, a visual teaching aid and a breastfeeding basic knowledge quiz.

An objective of my fellowship was not only to improve my knowledge but to share it with my co-workers. Through in-services and distribution of the tools I have created I hope to continue to help improve our bedside support and move forward the possibility of creating a breastfeeding support program within our hospital.

This fellowship allowed me to follow a route of my passion, and in doing so I not only grew professionally but personally as well. Over the three months I grew knowledgeable, capable, confident and even more passionate personally and professionally. It was an irreplaceable experience. Thank you to my supportive mentoring team Susan Lepine, Melissa Dougherty, Edith Kemerman and the management staff at CHEO who supported me completely throughout the entire experience.

**Creating/Adapting a Bereavement Program for the Neonatal Intensive Care Unit**

**Fellow:** Aloysius Hawkins, Children's Hospital of Eastern Ontario

**Mentors:** Susan Lepine, Children's Hospital of Eastern Ontario, Lori Ives-Baine, The Hospital for Sick Children, Monette Boudreau-Roth, Children's Hospital of Eastern Ontario and Marion Rattray, Children's Hospital of Eastern Ontario

I would like to thank the RNAO and senior management at CHEO, for providing me with the opportunity to participate in this clinical fellowship. In doing so I have gained a better understanding of the grief experienced by families following a neonatal death.

Over my extensive nursing career in the NICU, I have encountered many families and have always felt the overwhelming emptiness created when they leave our unit following the death of their baby. My desire to better help these families prompted me to seek this clinical fellowship. It is by understanding the unique reactions that friends and extended family members often show towards our grieving parents, and through recognizing other significant confounding factors that play a role in intensifying the parents stress and subsequently their grief, that I will be able to communicate in a more meaningful way to these support persons this in turn will enable them to be more supportive of the parents' needs.

In contacting 28 other neonatal units throughout Canada, I created linkages and partnership for sharing information. These contacts also showed me that for the most part, as healthcare professionals we as caregivers still fail to recognize the full impact of the grief experienced by parents following the loss of their baby. As care facilities, we do well in helping families create lasting memories of their baby but few of us have a structured bereavement program in place to provide adequate and meaningful follow-up.

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My site visit to the Hospital for Sick Children in Toronto showed me that where a structured program exists, we can better support our staff and in turn better support our bereaved parents through their grief journey. As well as providing ongoing education to their staff, their bereavement program provides follow-up calls, newsletters and remembrance cards to parents for a period of one year following their loss.

The contacts I made with community and religious leaders emphasized the need to ask families what their wishes are rather than assuming that because they are from a particular culture or practice a particular
religion, that they comply with the common practices of that culture or religion. This is why it is so important for us to be able to individualize our bereavement care programs.

The staff survey that I conducted identified specific educational and documentation needs of staff. In supporting our staff, we enable them to better care for the families we service thus leading these families through their grief experience.

Parent interviews revealed that parents were very appreciative of all that nurses did for them. Comments like “I don’t know what we would have done without the great staff there” were repeated. Parents also stated “we would like to have heard from the nurses after (name) died, to thank them for all they did and just to be able to speak to them again”.

Creating a structured bereavement program to support the needs of staff as well as meet the needs of the families during their initial crisis will help families cope with their grief in a positive way and adapt to their new life without their baby.

I would like to convey a very special thank you to my mentors, Ms. Susan Lepine, Mrs. Marion Rattray, Mrs. Lori Ives-Baine, Mrs. MonetteBoudreau-Rohl and Ms. Debbie Hogan, for their guidance, their encouragement and understanding, as well as for sharing their expertise with me as I undertook this educational experience. I would be remiss if I did not also thank all my fellow colleagues for participating in my survey and for their never-ending encouragement for my project. Thanks to all those in other neonatal units as well as my community contacts who were so willing to share their time, their experiences and their resources with me. It truly is teamwork that made this fellowship such a learning experience.

**Management of Procedural Pain in the Paediatric Emergency Department**

**Fellow:** Kymberly Newhook, Children's Hospital of Eastern Ontario

**Mentors:** Patricia McCarthy, Children's Hospital of Eastern Ontario, Tracy MacDonald, Children's Hospital of Eastern Ontario, Megan Wright, Children's Hospital of Eastern Ontario and Jacqueline Ellis, University of Ottawa

During the course of the fellowship entitled improving procedural pain in the pediatric emergency, I was able to examine the literature related to interventions for procedural distress from common procedures performed in the emergency department (ED) such as intravenous, blood work, intramusculars, lumbar punctures, urinary catheterizations, and nasal gastric tube insertions. I was able to generate interest in our ED by posting relevant articles and facts on the pain education board outside our staff room. By conducting a survey on nursing practices, attitudes and perceptions regarding procedural distress, I was able to understand some of the barriers and supports for good procedural pain management (PPM) in the ED of the Children's Hospital of Eastern Ontario (CHEO). Findings from the survey revealed that although nurses felt than IVs were painful and caused anxiety, and topical anesthetic was effective, it was applied only between 0-25% during typical practice. One of the future challenges will be to help the nurses understand the benefits of good PPM and incorporate the use of topical anesthetic into their busy work. The Patient Service Assistants were found to be informal helpers for nurses in PPM. The survey was followed with 2 separate focus groups. Surprising information was discovered in the focus groups. Contrary to research, the discussions revealed that nurses perceived the pre-procedural teaching by a skilled child life specialist to be anxiety provoking rather than anxiety relieving. There is an educational component of interventions to prevent procedural distress which needs to be addressed in our department.

Besides examining some of the attitudes of nurses in the CHEO’s ED I was also able to look outside my own department. Telephone interviews were conducted with 5 centers in Canada and 3 in the United States. The telephone interviews revealed that CHEO was more progressive in PPM than some other Canadian centers, but lagged behind in others, including the 3 American sites. All hospitals agreed there was tremendous growth in the last 10 years in PPM. A site visit to the Children’s Hospital of St. Louis provided some very interesting information on innovative techniques for PPM. I had the opportunity to meet with a number of pain specialists at this hospital during a two day site visit. Some of the interventions observed in their ED, included the use of nitrous oxide for minor procedures, and injecting buffered lidocaine pre IV cannulation.
The information gained throughout my fellowship produced the following recommendations:

1. To increase the use of topical anesthetic usage pre IV cannulation
2. To increase the use of pre-procedural teaching
3. To increase the use of positions for comfort
4. To support the use of distraction for PPM
5. To provide a formal pain prevention education ½ day for the patient services assistants
6. To further examine some of the innovative strategies used at St. Louis Children’s Hospital such as nitrous oxide inhalation for minor procedures and the use of 1% injected subcutaneously pre IV cannulation
7. To share fellowship findings with the ED physicians group, key stakeholders in pain management, including information derived from the literature on use of buffered lidocaine pre-laceration repair.
8. To continue to investigate the use of 2% lidocaine jelly application pre-urinary catheterization, interventions for auger suctions, eye flushes and the use of lidocaine pre NG tube placement.

With the tremendous support of my operations director, a multi-disciplinary emergency department procedural pain committee will be formed. The committee will be reviewing my findings from the fellowship, and by utilizing the RNAOs toolkit for implementation of clinical practice guidelines, we will implement the recommendations from the fellowship work.

Developing an Evidence Based Educational Program for Health Care Professionals Providing Decision Support for Parents Dealing with End-of-Life Decisions in the NICU

Leadership Fellowship
September 17, 2007 - December 9, 2007

Fellow: Cheryl Auberton, Children's Hospital of Eastern Ontario

Primary Mentor: Sandy Dunn, Children's Hospital of Eastern Ontario

Given the rapid escalation of neonatal technology, health care professionals (HCP) have not had sufficient time and training to adjust to the difficult end-of-life decisions. Advanced technology used to save smaller and sicker infants leads to complex questions regarding treatment options. Often, HCP are uncomfortable in how to approach parents and discuss these difficult decisions. This dialogue may also be hampered by a lack of understanding of HCP’s and parents’ roles in the decision making process (Becker & Grunwald, 2000; O’Connor et al., 2003).

Supporting patient and family involvement in decision making is strongly embedded within the principles of client centered care including respect; human dignity; clients as experts of their own lives; advocate clients’ goals and coordinate care within the health care team. These principles are also consistent with professional nursing standards of care, and the list of competencies developed by the Canadian Nursing Association that reflect multiple sources of knowledge. Yet NICU staff at the Children’s Hospital of Eastern Ontario (CHEO) has received little or no structured education with which to support parents in making difficult decisions at the end-of-life.

The goal of this fellowship from September to December 2007 was to improve decision support for parents faced with end-of-life decision-making in the NICU by building the knowledge, awareness and skill capacity of the NICU nurses. The fellowship focused on examining the unique experience parents face when having to deal with difficult end-of-life decisions for their infants. This knowledge was then used to develop and pilot test a program aimed at providing information on: decision coaching offered at the various stages of decision-making; guidance in steps of deliberation and communication during decisional support; and personal value clarifications.

This fellowship offered the opportunity to:

- Develop expertise in completing a literature search and in creating a permanent SDI (selected dissemination information) automated search update;
- Increase knowledge and skills regarding decision support specific to the needs of our NICU patient population;
• Develop an understanding of effective strategies to disseminate information and becoming a change agent;
• Develop and enhance my leadership skills (communication, presentation, team building, time management and strategic goal setting);
• To support further development of high quality decision making through the NICU Decision Support committee at CHEO;
• To become an active contributor to the continuing evidence-based practice in our NICU.
• The first step in the process to assist nurses in decision support methods was to gain knowledge and confidence in decision support framework. In order to meet this objective, the following activities were completed:
  • Creation of a comprehensive bibliography on topics related to decision support, shared decision making in general and related to end-of-life decisions in the NICU
  • Participation in regular discussions with mentors, other health professionals involved in other community decision support initiatives and the CHEO and Ottawa university librarian, for clarification on fellowship process when needed.
  • Attendance at several workshops with specific emphasis on the utilization of the Ottawa Decision Support Framework and as well as other decision support methods.
  • Attendance at the RNAO Ethics videoconference.

The next stage included developing an evidenced based educational program based on knowledge gained in the first step of the fellowship. Finally, I was able to experience the initial stages of knowledge transfer by sharing the program with a selected group of NICU staff members.

In particular this experience has allowed me to expand my knowledge in methods of supporting parents; understand that decision support includes more than knowledge for parents faced with end-of-life decisions; identify nurses’ unique position in supporting parents with decisional conflict related to end-of-life decisions; and the appreciation that decision support reflects a Family Centered approach to parents’ decision conflict related to end-of-life decision making. After sharing this knowledge with colleagues, I believe this will facilitate awareness, knowledge and skills that will enable nurses to better understand and support parents with these difficult decisions they face while in the NICU.

Acknowledgements: I would like to thank the Ministry of Health and Long Term Care and the RNAO for offering such an opportunity for me to take this journey. To the Children’s Hospital of Eastern Ontario and NICU staff for their ongoing support, Sandy Dunn (Primary Mentor), Mary Ann Murray (Mentor), Dawn Stacey (Mentor) and Debbie Aylward (Mentor) for providing never-ending guidance along the way.

Fostering Professional Nursing Practice on a Tertiary Care Inpatient Pediatric Oncology Unit

Fellow: Patricia McCarthy, Children's Hospital of Eastern Ontario

Mentors: Carolyn Kennelly, Children's Hospital of Eastern Ontario, Pat Elliott-Miller, Children's Hospital of Eastern Ontario & Andrea Marie Laizner, McGill University Health Centre, The Royal Victoria Hospital

The realities faced by oncology nurses today, such as the ever increasing acuity of oncology patients, staffing, safety and workload issues challenges the focus and spirit of even the most seasoned oncology nurse. The nursing staff on the inpatient pediatric oncology unit at this hospital are very junior. There are 28/40 nurses under the age of 29 years. We need to develop strategies and systems aimed at developing the skill and confidence of junior nurses to face the complex realities of everyday practice.

The purposes of this fellowship were

1. To examine the factors and processes that foster professional nursing practice on a tertiary care pediatric oncology unit, and
2. To develop an understanding of the leadership skills and strategies that create positive change within a nursing system. The learning from this fellowship will be utilized to infuse the oncology program with energy and momentum and to foster the growth and development of junior oncology nurses.

During this fellowship experience, the candidate utilized multiple methods to immerse herself into the culture of the inpatient unit. She conducted literature reviews on practice models and empowerment of nurses. She conducted focus groups with nurses, utilized observation and informal discussions with patients/families and nursing leaders on the unit and maintained a reflective journal. She discussed ideas and progress with her mentoring team regularly and consulted with nursing experts during a site visit to a center of nursing excellence. An integrated plan for fostering the growth and development of junior oncology nurses was developed. This plan includes implications for nursing practice, education and research.

This fellowship was fully supported by the senior leadership of the hospital and the oncology program directors. The learning from this fellowship will have benefit not only for the oncology program but the hospital as a whole. The hospital where the candidate works is moving to a shared governance structure. The focus and scope of practice of the Advanced Practice Nurse role within a shared governance structure has been broadened to include shaping other nurses practice, thus the candidate will have dedicated time post fellowship to continue to build on the achievements of this fellowship. The Nursing Advisory Council is fully committed to integrate relevant deliverables from this fellowship into their strategic plan for nursing services. Ultimately, oncology patients and families will be better served as bedside nurses gain the confidence and skill required to provide quality-nursing care.