In this second part of a two-part series, writer Sue Cavanaugh takes a closer look at what Nunavut’s mothers-to-be can expect when they’re expecting, and how nursing professionals across the territory are thriving. Canadian Nurse would like to thank the Nunavut Department of Health and Social Services for their generous support of this feature.
 Nunavut has the highest birth rate in the country. Although each of its health centres is equipped with an obstetrical birthing pack, women in labour, and even those who might be, are medevaced out of their community. The birth rate ensures that nurses have lots of contact with pregnant women. This is especially true for community health nurses; as the primary health care practitioners in most communities, they provide the majority of prenatal care.

Depending on where they live, mothers-to-be go either to their main regional centre or out of the territory altogether to give birth. The standards differ slightly from region to region, but women are generally expected to leave their communities at 36 weeks to move to a special residence or hotel near the birthing facility. And since predicting labour is not an exact science, this “boarding-in” phase can last for a month or more, during which time many women are separated from their families. It can be particularly hard for those who already have young children at home.

One of the two birthing centres in the territory is at Qikiqtani General Hospital in Iqaluit. For more than 35 years the hospital has provided labour and delivery services to women in the Baffin region. With more than 400 babies delivered there last year alone, it is a busy unit. A new facility, opened in 2007, includes four birthing rooms and a nursery, although mothers are encouraged to keep their babies in the rooms with them. At less than eight per cent, the hospital’s C-section rate is the lowest in the country, and if they are otherwise categorized as low risk, women who have previously had C-sections can choose to deliver via VBAC, with surgical backup available if necessary. Very few women in Baffin have to leave the territory to give birth; when they do it’s because they’re considered high risk — for example, if pre-term labour begins at less than 33 weeks’ gestation, or if they’re carrying twins or multiples.

Births at Qikiqtani General generally involve fewer interventions than hospital births in the south. Inuit women often don’t even arrive at the hospital until their labour is well under way. One nurse explains the low-key nature of the experience: “Women aren’t strapped down to a machine; they’re walking around doing their own thing. We check the baby’s heart rate and vital signs, but otherwise it’s very hands off. When they’re ready to push, they let us know. It’s very calm, an amazing thing to watch.”
Rankin Inlet’s birthing centre is staffed by midwives. The local Inuit population lobbied to bring them to the region to give women the option of staying there to give birth. Midwifery is not a regulated profession in Nunavut, and the Kivalliq region is the only one with midwives at present. At one time, communities in the Northwest Territories had British-trained nurse-midwives working in their health centres, enabling women to stay home to give birth. However, changes in regulations and immigration laws saw those nurse-midwives disappear by the mid-1960s.

More than 600 deliveries, with not a single case of maternal or infant mortality, have occurred at the birthing centre in Rankin Inlet since it opened in 1992. A University of Manitoba audit in 2005 found that the centre had consistently provided safe maternity care. About 20 per cent of the 250 births per year in the region take place at the centre; the remaining 80 per cent of the women choose to go to Winnipeg or are sent there because they are at high risk for complications. The midwives and community health nurses encourage those at low risk to stay in the territory and give birth in Rankin Inlet, and although the numbers are still relatively low, they are growing each year.

Arviat, Kivalliq’s largest community, boasts the highest birth rate of any community in Canada, but women have to go to Rankin Inlet or Winnipeg to give birth. These flights represent a third of the cost of all medical travel in the region; even a low-risk delivery costs the health system $12,000. Norm Hatlevik, the Department of Health and Social Services executive director in Kivalliq, would like to see a birthing centre in Arviat modelled on the one in Rankin Inlet; families would not have to be separated and there would be huge savings to the health system.

Cambridge Bay, the regional centre in Kitikmeot, has no birthing centre, and pregnant women are sent to Yellowknife or Edmonton. The region is currently looking at the time frames set for leaving communities, with the idea that low-risk mothers could be assessed on a case-by-case basis instead of automatically being sent out at 36 weeks. Cambridge Bay has been identified as the next site for a birthing centre, with midwifery services targeted to begin later this year.

The government has passed a new Midwifery Profession Act (regulations are pending) and a maternal and newborn health-care strategy is
currently being developed, but there are concerns that it may be difficult to recruit enough midwives, given the fairly small number of them in Canada. To date, 10 Inuit maternity care workers have graduated from the Maternity Care and Midwifery Education Program at Nunavut Arctic College; two graduates have gone on to become midwives. This unique program teaches traditional Inuit practices and western medicine.

The fetal fibronectin test is a tool used in many communities to reduce unnecessary early travel. Fetal fibronectin is a glycoprotein that resides in the lining between the placenta and the uterine wall. In a normal pregnancy, the protein stays put between 25 and 35 weeks; it does not appear in vaginal secretions. If it does appear during this period, it is an indicator that labour might begin sometime in the next seven days.

The default management mode for suspected pre-term labour has been to immediately medevac women at 32 weeks or less gestation who had any vague signs or symptoms of labour. Community health centres are not equipped to deal with premature babies, and the potential for severe morbidity and mortality meant that the threshold of when to call the medevac is very low.

An interprofessional pilot project that began in 2004 introduced fetal fibronectin test kits in four health centres and at the hospital in Iqaluit. The test consists of a simple vaginal swab that is placed in a processor; results take about 30 minutes and are an easy-to-read positive or negative. If the test is negative, the chance of a woman going on to deliver the baby in the next seven days is about 0.4 per cent. Dr. Sandy MacDonald, director of medical affairs at Qikiqtani General, headed up the project: “All other things being equal — no cervical dilatation, no painful regular contractions — a negative test is one more reassuring piece of evidence.” Nurses and other clinicians used the test to help them determine whether women were truly in pre-term labour.

After two years, the results showed that there had been no false negatives and uptake among clinicians was good. The project team reviewed charts and estimated that the tests had saved up to 20 unnecessary medevacs. Nurses reported feeling confident using it and felt it helped them to make good clinical decisions for their patients. Based on that response, the test kits were put into most health centres across the territory. The cost per test is $100, but well worth it when compared to the cost of a medevac flight. Between 2004 and 2007, more than 160 tests were performed across the territory, leading to savings estimated at several hundred thousand dollars per year.

MacDonald and his team at the hospital have since partnered with researchers from the University of British Columbia and the University of Ottawa in a new project. They are investigating the use of the test as a predictor of when women who are between 36 and 40 weeks’ gestation will go into labour — would the absence of the protein reliably predict the absence of labour over the next seven days. If so, the test could be used to help women stay home later in their pregnancies.

The research project will follow 20 women who are between 36 and 40 weeks and are in Iqaluit waiting to give birth. They are tested every other day, and tracked to see when the test result goes from negative to positive — and when their labour begins.

The tests are purely for collecting data and are not being used as a management tool or in making decisions. If the results look promising, the researchers want to expand the project to multiple sites and follow at least 100 women to get a clearer data set. Preliminary results are expected to be released this summer.
NURSES TO KNOW

NANCY McGrath, a nurse at Iqaluit’s Qikiqtani General Hospital, had a minor panic attack when she first arrived in Nunavut five years ago — she hadn’t anticipated that there wouldn’t be any trees. Originally from Corner Brook, N.L., McGrath had been working in intensive care at the hospital in Stephenville but was looking for a change. She’d heard about opportunities in Nunavut from a friend and thought she’d give it a try. Her original contract was for a four-month term. Now, she says, “I take it one January at a time, and every January I think, OK, am I going to stay here another year or is it time to go? And… I’m still here.”

“You never know what you’re going to get here, and I just love that aspect,” she says. She works in every ward — obstetrics one day, pediatrics the next — and some days, she’s the acting nurse manager. McGrath is also pleased with the educational opportunities her employer offers, far superior to what she would receive down south, she believes. Since moving to Iqaluit, she has attained certification in neonatal resuscitation, CPR, advanced cardiac life support, non-violent crisis intervention and pediatric advanced life support; she’s also an instructor in fetal health surveillance.

Her husband, a fellow Newfoundlander she met in Iqaluit, works for First Air. McGrath is able to take advantage of significant discounts — a trip to Ottawa costs her about $26. She knows how lucky she is to have this opportunity and jokes that her husband tells her, “you only married me for my connections.” They plan to move back south one day to start a family, most likely to Ottawa, but they’re thinking about staying on for another three years. The distance from family and the high cost of living in the territory are a challenge, but with the standard vacation allowance and her banked overtime, she gets about two months of vacation a year. In Nunavut, “the government gives workers their vacations, no matter what,” she says. “I will probably see my family more if I stay on in Nunavut than I would if I moved to Ontario.”

Throughout her career, ROBYNE RUFF has met a lot of nurses who are grumpy and miserable in their jobs. A community health nurse in Baker Lake (pop. 1,728), Ruff has been working in the north since 1993, and says, “I love going to work every day. I’d have to go somewhere else if I was that unhappy.”

When she graduated from Winnipeg’s Misericordia Hospital school of nursing in 1992, there weren’t many full-time nursing jobs available. She started working for different private and government agencies. At her first job in the north, in Poplar River, Man., she was fortunate enough to be taken under the wing of a long-time nurse who showed her the ropes and paved the way for her to “fall in love with northern nursing.”

Like many other nurses who work in rural and remote communities, Ruff appreciates the fact that “there’s never a dull moment” — she gets to use her knowledge and skills on a daily basis. She recounts a time when Baker Lake was snowed in for two days: “We had seven inpatients who needed to be medevaced out; they just kept coming in, one with a heart attack, one with acute abdominal pain…. We ended up calling ourselves the Baker Lake Hospital. It was kind of fun, actually.” The nursing team ran 24-hour shifts and were able to keep everyone stable until the planes arrived. They were fortunate that there was a doctor in the community at the time.

When asked what makes someone a good community health nurse, Ruff laughs, “Our health centre is fully stocked, but I always say I could fix almost anything with toast, tea and duct tape!” She’s joking, but her experiences have taught her that being able to think outside the box when emergencies arise is an invaluable skill. Getting involved in the community helps too. Her family have settled into life in Baker Lake, and she is learning how to speak some Inuktitut. She also volunteers at a lunch program at the local hospice most Fridays and now knows all the local elders.
In Conversation with Fred Montpetit

Fred Montpetit, a former public health regional manager and director of nursing in Rankin Inlet, is Nunavut’s first chief nursing officer. He came into the newly created role last January to address some of the growing pains and challenges that nurses and the health system are facing in the territory.

How did you end up in Nunavut?
I grew up in a town called Bowmanville, just east of Toronto. When I was in my third year of nursing school at Algonquin College in Ottawa — I was a diploma nurse originally — Nunavut recruiters came down looking for nurses to explore the north. I got the bug at that point, and at the first opportunity I got after graduation I came to Nunavut. That was seven years ago.

How would you describe your role?
The position was created as a promise to nurses, as part of the recruitment and retention strategy. Physicians have always been represented by a director of medical affairs, who answers to the deputy minister, but nurses have never had a voice, and there are 10 times the number of nurses as there are doctors. I advise the deputy minister on nursing matters and represent nursing at the senior management level.

What have you set as priorities?
One of the top priorities is to have a structure established with the authority to make decisions about nursing practice, like a nursing advisory committee you’d find in some hospitals and health authorities. The committee would consist of the nursing directors from the regions, a community health nursing specialist, a public health nursing consultant, a senior nurse practitioner and a home care nursing consultant.

Of course, the recruitment and retention strategy is a departmental priority. And while human resources is leading recruitment efforts in the south, I am focusing on recruiting Inuit into the nursing profession and retaining all our nurses.

I have also set some long-term goals for myself. One is to set up a certification program for northern nurses. Right now we have no way of certifying our nurses as specialists in outpost nursing. What I’d like to see, in the next two or three years, is the establishment of an introduction to advanced practice that would certify nurses for working in the north.

What qualities do you look for when you’re interviewing applicants?
We want people who have a sense of adventure. You need to be very flexible to do the job, and adventurous people seem to be a bit more flexible. And we’re looking for nurses who have great skills in emergency.

So it’s not necessarily that you’re looking for mid-career nurses with years of experience…
Well, experience certainly helps, and self-direction is also very important. You need to be able to learn. If you’ve not educated yourself since nursing school, then you’re going to struggle. We need people who are good critical thinkers and have solid assessment skills. Without those qualities you don’t have the foundation upon which to make a diagnosis.
What’s the scope of practice of community health nurses?

It’s incredibly broad. They have to be very good at dealing with emergencies like motor vehicle accidents or pre-term labour. But on top of that, they are the primary care providers in most communities — only three have doctors on a permanent basis. Mornings in the community health centre start with a sick clinic, covering everything from colds, rashes and broken limbs to sutures and aches and pains. And then in the afternoons, if everything’s calm, the centre becomes a public health clinic. Basically, community health nurses need to be able to do just about every health-care function that exists.

What’s the staffing level at the health centres?

It varies with the size of the community, but usually there are between two and six RNs, including one nurse in charge. In addition to the RNs, there is a community health representative — an Inuit person trained specifically in health promotion — to do health teaching and health education. Clerk/interpreters provide services for the nurses; many unilingual elders do not speak any English. In most of the health centres, the janitors are trained to take X-rays and may also drive the medevac ambulance; clerks and housekeepers are trained in equipment sterilization. Everybody adds on to their jobs.

Some health centres also have a home care nurse, a mental health nurse and/or a mental health worker.

How does the medevac system work?

When it’s clear that someone needs to be flown out, the nurse alerts the physician on call and explains what’s going on, and the physician on call starts the medevac process. Before the plane can be called there has to be a receiving physician available in the south. Once that is set up, the process starts and the standard is about 45 minutes from the moment the plane gets the call until it is off the ground. If the nurse feels that the patient needs a doctor or a midwife, and there is one available locally, the plane will pick someone up on the way. You could conceivably get somebody medevaced out in two to three hours after an accident happens — that would be the minimum amount of time. But if the weather is bad, the community health nurses might have to manage a critically ill patient for days.

So if you’re a community health nurse there is the possibility of quite a bit of acute care work...

There is a ton of acute care. That’s why the best nurses have emergency experience.

Many nurses work here on a casual basis for a month or two before they take on full-time contracts. They have a very strong awareness of what they’re getting into. There is a steep learning curve, even if you’re coming from an emergency department in the south, where there are respiratory techs and emergency physicians and specialists and interns and med students, not to mention a team of four or five nurses where each one has a very specific job — airway, medications, fluids or lines and cords. When emergencies happen up here, you don’t have that team. There may be just two nurses, who are responsible for everything, until someone can get in to help.

What sort of training do nurses get before they go into the community health nurse role?

We start with a skills assessment for everyone. Some nurses who are mid- to late career, who have a number of years of experience and who’ve worked emergency before, may take six weeks or more to feel comfortable. They are always buddied with someone to start and are never on call alone. It depends on individual regions and managers and what they allow staff to do to start.

I would like to see that process standardized. It falls under credentialing and quality assurance. Certifying nurses and ensuring they’re trained adequately and properly is an important piece of what we do.

When we hire our new grads from Nunavut Arctic College, we’re looking at up to a year of mentoring or interning. We try to keep them outside the staffing complement, and make sure they have a dedicated trainer. Elements are taught slowly, but it starts with the assessment and an understanding that it is a long process.

What about nurse practitioners…how many are there in Nunavut?

Most of the nurse practitioners in the territory are working in the community health nurse role. I believe there are four positions that are specifically for nurse practitioners, where they have the ability to prescribe in accordance to legislation. Three are based in Iqaluit, and one is in Rankin Inlet. The government is working on a plan to have more of them working to their full scopes of practice in our community health centres.

Overall, I think that we are on the forefront of nursing practice. The nurses who work up here are really the crème de la crème.