Co-President’s Comments: The changing landscape of Clinical Nurse Specialist education and practice.

This is an exciting year for Clinical Nurse Specialists (CNS). The Canadian Nurses Association (CNA) unveiled the “Pan-Canadian Core Competencies for the Clinical Nurse Specialist” at the Biennial Convention and AGM in Winnipeg in June of this year. This document will set the stage for further work that will lead to national certification. As expected the CNS required a graduate degree in nursing, with a clinical focus. This advance nursing practice role is a clinical role and is engaged in patient care bringing advance knowledge and skill to solving health problems that may be common problems or that are evident in an unusual case. I can say I was there, and bore witness to the excitement at the release of this latest document marking the journey to recognizing and legitimizing CNS education and practice in Canada.

Nursing has evolved many roles that ‘nurse the system’ and in time these will need to be defined and explicated. The lack of clarity around the many ways nurses with advance education play a part in the system has led to a misuse of available titles such as CNS. Identification of the competencies and eventual certification will hopefully prevent misuse of this title as a catch all for every nurse with a graduate degree who plays a role in health care. The public has a right to benefit directly from specialist in clinical practice. This new initiative will also impact graduate education in nursing as the CNS programs were replaced by Nurse Practitioner programs when that specialty was legislated. Identifying the content of programs will also need to consider trends around the world. Curricula will need to include the right type of course work and clinical experiences including clinical hours for a Canadian CNS to be recognized as a peer by the CNS communities in other industrialized countries. We do not live in isolation. The United States is moving from a Master’s degree with a minimum of 500 hours of supervised clinical practice to the Doctor of Nursing Practice (DNP) with a minimum of 1,000 hours of supervised clinical practice as the entry point to practice as a CNS. This will indeed challenge Canadian Schools of Nursing who provide graduate education. The North American Free Trade Agreement (NAFTA) allows mobility of professionals between Mexico, Canada, and the US, if education and credentials are equivalent. At this time a US educated CNS can move freely, but those with Canadian and Mexican credentials cannot. This creates a reality where US CNS’ are better qualified for Canadian CNS positions than Canadian graduates.

The lack of faculty with qualifications to teach advance practice will also be a challenge. Most...
faculty members gave up clinical practice years ago as practice, education, and administration each grew in their own silo. This is the history of the profession and will need to be revisited as clinical currency will be essential in order to educate the next generation of advance practice nurses. The awareness of this problem is not unique to Ontario or Canada. I recently had the privilege of presenting a research paper at the International Nurse Practitioner/Advance Practice Nurse Network conference in Helsinki, Finland. I also had the opportunity to hear what was happening with advance practice around the world.

In particular, I attended a presentation by Dr. Bonnie Pilon from the School of Nursing at Vanderbilt University, one of the Ivy League universities in the US. She started by sharing that some years ago her colleagues had asked the question “how do we teach students current practice knowledge if we are not currently practicing?” This is a difficult question that some answer by insisting the ‘teaching is practice’, however if that is true, then all teachers are nurses. Obviously that corollary makes it clear that teaching about ‘something’ is not the same as doing the ‘something’. Dr. Pilon and her colleagues decided to find ways to practice as part of being an academic in a nursing program. They found creative ways to develop and fund a variety of Academic Affiliated Nurse Led Clinics, ranging from clinics for private sector employers. The profitable clinics fund those that do not generate profit. Students learn to practice nursing in these settings as well. In the beginning, only one faculty member practiced clinically. The numbers have grown significantly. At this time she reported 103 full time and 24 part time faculty members actively practice clinically in one of the 4 different settings they have developed, and are board certified in a variety of specialties. The clinics themselves are staffed with 26 full time faculty members and 4 part time faculty members with a range of 7-10 years’ experience. This group has produced 27 publications and 31 presentations as a result of their work. The school graduates 300 graduate and doctorally prepared nurses annually.

This presentation was well attended with nurses interested in following this model in other academic settings. Hopefully this is a sign that the silos separating nursing into discreet groups will begin to break down in the future. Consider that any nurse who teaches clinical courses in a nurse practitioner program is required to be currently registered, and practicing, as a nurse practitioner. It is highly likely that for an academic to teach clinical courses in a CNS program in the future, a similar requirement will be in place. These trends are signs supporting a healthy future for nursing practice. As an academic who misses clinical practice I was quite excited in hearing about these trends.

Let’s move further into ACTION !
Co-President’s Comments:

Hello Nursing Colleagues,

We are back to work full speed, the holidays are over for most of us. We are forecasting new activities for the members. This year (2014-2015), we are planning free webinars for our members, either via RNAO or via CNA. We will be looking into it.

Also, in this newsletter, I have summarized some of the workshops that I have attended last March in Orlando, Florida. There is more information on the website. Also, there is all the abstracts publication by the NACNS, in the CNS Journal.

I continue to represent CNS at various functions including the Assembly of President in Toronto, during my interviews in the media (radio, television, etc.), in social medias such as Facebook, Twitter, LinkedIn, and on our website, I keep adding some material. In order to be most efficient, we need to receive information from you the members. Your suggestions are important to ensure that we stay relevant.

We have continued to publish information regarding the best practices that clinical nurse specialists are involved. It should assist you in having more ideas about what is done elsewhere that will inspire you in your day-to-day work.

Lately, I am still enthusiastic about my own practice when I keep learning approaches that help me to remain efficient when they are not necessarily well known to nurses. For example, in a research by Tembel et al. (2010), we can read that during the oncology treatments of patients, if health care professionals begin immediately palliative care, the level of pain of patients is lower and better controlled, better quality of live, their sense of control is also better, they are less depressed, and their survival rate is better! In the research done with 151 participants, the median survival was 11.6 months for patients receiving early
palliative care compared to those not receiving it (8.9 months). There are significant improvements.

These are examples that enable us, health care providers, to implement better practices. In some hospitals in USA, they not only have CNSs on staff, but hospital administrators have increased their number up to 15 and 20 in some cases. The results were evident during the March conference (NACNS). The critical mass (numbers) is key in achieving more successes. Their financial investments are paying off. There is HOPE! -

Can we do this in Canada? We can definitely say — yes! It is one of the reasons that we are lobbying the Minister of Health and the Premier of Ontario. Pictures in the previous newsletters attest to this. But it is the responsibility of all of us to increase better outcomes of patients, and talking about it—is one of them. We need to write about it, talk in the media about it, provide examples in newspapers, and in our newsletters.

On the other hand, schools and faculties of nursing have to develop further their CNS stream and ensure to have a minimum of 500 hours of practice in a clinical specialty. Only at the Master’s level, that RNs can specialize and become CNS. The expectation in North America has changed for the new CNS being educated. In the USA, they are looking at having a DNP (doctorate). In Canada, we will keep the education of CNSs at the Master’s in Nursing level (the numbers of masters’ prepared CNS are too low to move now at the doctorate level as a requirement). Also in Canada, we continue to indicate that CNS do not need prescriptive authority for medications. At this point in time, we are glad to leave this aspect of care to NPs. Furthermore, we need to identify universities that have a CNS Nursing Program (graduate level), and those with more than 500 hours in nursing specialties. Send us your information about Ontario and about these programs across our country.

When we are talking about various categories of nurses, in Ontario we have RPNs, RNs, NPs, and CNSs. In Western Canada, they have Registered Psychiatric Nurses. For the future, we are promoting the APN-CNS role, let’s be clear, when patients hear that I am a clinical nurse specialist, they understand well the word “specialist.” In my practice, I have developed my expertise over the past 23 years in palliative care. Every week, I have the opportunity to meet patients, families, nurses, and other members of the palliative care team in Sudbury, keeping current is key in improving care, and still contributing to the health care system. My colleagues on our Executive have years of experiences in their own clinical specialties and are well recognized as such.

So, we invite you to develop and become specialist in your own practice, mentor each other, and share with the rest of us… what you do in your workplace.

Sincerely,

Paul-André Gauthier, RN, CNS; DMD, MN, PhD (Nursing)
Clinical Nurse Specialist in Palliative Care.
Sudbury, Ontario.

Suggested article to read:


Canadian Nurses Association published the competencies of clinical nurse specialists (CNSs) in June 2014. There were consultations leading to the final version.


Competencies: (EN)
http://cna-aiic.ca/~/media/cna/files/en/strengthening_the_cns_role_background_paper_e.pdf

Compétences: (FR)
http://cna-aiic.ca/~/media/cna/files/fr/clinical_nurse_specialist_role_roundtable_summary_f.pdf
http://cna-aiic.ca/~/media/cna/files/fr/strengthening_the_cns_role_background_paper_f.pdf

Other info:
CNS Association of Ontario – Ottawa satellite group

By Carmen Rodrigue
RN, MSc, CPMHN(C)
Chair, Ottawa satellite.

The Clinical Nurse Specialist Association of Ontario - Ottawa satellite group met on Friday April 4th, 2014 for a breakfast meeting. Our guest speaker was Ms. Josette Roussel, Senior Nurse Advisor, Professional Practice at the Canadian Nurses Association (CNA). Her presentation focused on the future positioning of the Clinical Nurse Specialist (CNS) in Canada. Seventeen participants attending the meeting were engaged in a discussion pertaining to CNA’s vision of the CNS and were informed that CNA would be launching a document entitled “Pan Canadian Core Competencies for the Clinical Nurse Specialist” during the CNA Biennium in June 2014.

Your executive in ACTION!

RNAO-AGM-May 2014
Paul-André Gauthier

CNA-AGM-June 2014
Elsabeth Jensen

NACNS – President (middle)
March 2014 – Orlando, Florida
Elsabeth Jensen, Les Rodriguez, Paul-André Gauthier

[Absent from the photo: Dianne Rossy, Carmen Rodrigue]
Clinical Nurse Specialist in an Orthopedic Program

I am well positioned to be a leader of change to not only seek, but develop evidence-based interventions to improve the quality of care. The many branches of my role that keep me engaged and passionate include:

- Coaching patients to optimize their pre-op confidence and capacity promoting possible recovery as demonstrated in our current 3.1 day length of stay, exceeding provincial standards of 4.4 and readmission rates 2.9%.
- Leading projects, engaging Interprofessional members, to standardize consistency in care enabling the best patient experience and outcome as 90% of our patients having fractured hip repaired within 48 hours of admission.
- Implementing and sharing quality improvement methodologies with our team with evidence of care demonstrating successes, as well as opportunities for improved practice with improved communication and collaboration.
- Developing algorithms for complex care patients such as those with hemophilia who have shared there sincere appreciation for the proactive integration of care.

These results demonstrate the positive impact on patients, providers and the system in providing the best care, by the best provider, every time. I am grateful to the CNA for the opportunity to support a document providing the clarity and value that a CNS can bring in achieving a seamless, collaborative, efficient and evidence-based health care to enable the upmost patient experience.

Carole Caron  
RN, CNS; B.Ed., MA  
Clinical Nurse Specialist Orthopedics,  
Hamilton Health Sciences.  
Associate Clinical Professor Faculty of Nursing,  
McMaster University Medical Center.

Applying Clinical Nurse Specialist Skills in Parent Education

Providing patient education is challenging due to factors such as patient acuity and a shortage of nursing staff. Through their clinical expertise, research and competences, clinical nurse specialist (CNS) play an important role in promoting patient education (Chick, Negley, Sievers, & Tammel, 2012).

It is well documented that the premature birth of an infant and subsequent admission to the neonatal intensive care unit (NICU) create feelings of uncertainty and emotional turmoil for parents (Gulamani, Premji, Kanji, & Azam, 2013; Cleveland, 2008). In addition, the medical and technical nature of the NICU setting, including the various forms of technologies, use of medical language and frequent activities surrounding the infant’s admission, can affect parents’ ability to retain and comprehend the large amount of information provided during the initial admission period. In this regard, education is an important aspect of parental satisfaction with their NICU experience (Butt, McGrath, Samra, & Gupta, 2013).

For these reasons, streamlining the delivery of parent education through the use of smart technology to deliver evidence-based, relevant, timely, parent-centered, on-demand and patient-specific information to parents on their smart devices such as phones and tablets is one way in which the CNS facilitates and enhances the provision of education in this patient population. Smart technology such as an app can be used to meet parents’ informational and communication needs by designing, developing and piloting educational resources for NICU parents. By working alongside nursing staff and NICUs, a skilled CNS can systematically develop educational resources for parents to optimize the delivery of education, while incorporating and making use of modern technology.

Kadeen Briscoe  
RN, BScN, MScN (student).

References
As the editor:

I invite all members of the CNS Association of Ontario to send us notes, articles, pictures of interest for the next newsletter.

We are quite interested in your everyday practice, send us a short article to let your colleagues know what you are doing in your practice.

At: pgauthier@rnao.ca

Paul-André Gauthier

FYI:
- We have maintained a minimum of 250 members (RNs) over the past years. We do not have any undergrad nursing students. For ex.
  - For Oct. 31, 2011: 250 RNs
  - For Oct. 31, 2012: 251 RNs
  - For Oct. 31, 2013: 262 RNs
  - For Oct. 31, 2014:
    - Feb. 2014: 269 RNs.
    - July 2014: 289 RNs + 3 award recipients—(292). These numbers show that our Association is growing.
    - Oct. 2014… > 300?

Also, it means that we have enough members to receive a group discount by RNAO. We are currently pursuing this with the staff at RNAO and hope to have it in place shortly.

As we are moving forward with the CNS recognition, together we need to be involved locally, provincially, and also nationally to influence the health care system, nursing leaders and health care institutions. Now it is becoming imperative, with all the budget restrictions, to be more visible and to utilize our knowledge and advanced expertise to influence the health care outcomes and services. More reading...

October 2010 (chapters 1 to 12)

January 2011 (chapters 13 to 24)

August 2011 (chapters 25 to 42)


In May 2014

Nursing Student Awards were given to CNS-MN Student studying in Ontario. They received a certificate, a key chain, and we added them to the list of members:
- York University recipient—Kadeen Briscoe, RN.
- University Western Ontario recipient—Jeff Reed, RN.
- Ottawa University recipient—Mary Ann Laplante, RN.

Congratulations to all!

NACNS 20th Anniversary
March 5th to 7th, 2015
Loews Coronado Bay,
Coronado [San Diego],
California, USA.

The Clinical Nurse Specialist: The Essence of Transformational Health Care.
NACNS – Conference in Orlando, Florida.  
March 2014 – A Summary

Thursday, March 6, 2014
08:45 NACNS Awards were presented to recognize:
-Researcher of the Year
-Educator of the Year
-CNS of the Year
-Clinician of the Year
-Affiliate of the Year (state association)

09:15 Keynote Address: “Tomorrows Clinical Nurse Specialist: New challenge, new skill, new opportunity” • Dr. Maryann Fralic.

-Context: The importance of resilience, recognizing that as we are always learning, “One is always temporarily incompetent”, and “What got you here won’t get you there” Goldsmith (2007). Recognizing that Clinical Nurse Specialists are clinical innovation experts, possessing the ability to efficiently attend to the new challenges in our practice, continuously looking for new opportunities to improve.

-Hallmark: It is crucial that nurses and CNS’s possess the resiliency and confidence with the ability to integrate technology into practice. These skills will position them as leaders to then apply their competencies in the promotion of the highest quality health care system.

-Six compelling challenges:
-Continuously setting and achieving high standards (realistic);
-Competence is always at the forefront (absolutely none);
-Seeking an effective mentor, so as to then mentor others (succession planning);
-Engaging in continuous learning to support quality care provision throughout one’s career;
-Remaining engaged and receptive to developing and master complex new skills;
-Committing to serving our patients/clients well with meaningful interventions.

She added that “let’s not hide ourselves behind ‘APN’ title.”

Concurrent Sessions Summary:
“The great debate...Why CNS practice is still relevant”
• Elissa Brown; Deborah C. Messecar; Sharron Coffie
They reinforced the fact that we need clinical expert at the bedside. Resilience and perseverance are two important aspects that CNSs have. We should not forget to look at the system and understanding how it works in our own work environment.

“It’s how you do it – Achieving clinical outcomes”
• Elizabeth Duxbury; Michael Allain; Kelly Keenan
In their presentation, they emphasized that we can function independently. Develop a goal with the CNS’s director and work at achieving the goal. “What kind of glue that keeps the care together?” Help the nurses as consultant with complex cases. Increase the professionalism of nurses working in the team. Help the nurses to think further. Ask questions such as:

“How can we reduce the infection rate together?” When we implement a procedure there are financial benefits that improve the care and also that are financially worthwhile on the short term and long term.

“We are not a secret anymore: Increasing CNS visibility, influence and partnerships within an organization”
• Brenda McCulloch; Siobhan Geary; Theresa Lehman; Barbara Quinn
With 12 CNSs’ in their hospital, visibility is promoted with posters to increase awareness, even in elevators. The role of the CNS as one of influence to improve the quality of care is recognized with their active participation on committees. As a Magnet Hospital, their organization has realized financial gains resulting from the impact of the CNS in care delivery and such the value of their role.

B4: Clinical Management Lecture: “A multimodal approach to pain management”
• Amanda Lucas
Pain management. P. A. I. N. :
- Physiology of pain;
- Anxiety, emotional pain;
- Interpersonal problems, social pain;
- Non-acceptance, spiritual pain. (Fink, Gates, 2010)
Questions need to be asked: “Tell me about your experience with pain.”

-What is their ability to cope with pain? We have to demystify their perceptions that are wrong about pain. E.g. the stigma with morphine. There are a lot of tools that we can use to have a more accurate assessment of pain and then act to relief it as needed. We can look at long acting medication for basic relief. Providing client education.

-Reviewed ideal application locations for transdermal medications, as similar to subcutaneous injection sites (not over bones and where circulation is good) for optimal absorption of the medication.

Websites:
http://www.aacn.nche.edu/elnec/elnec-web-resources
http://prc.coh.org/res_inst.asp
The American society of pain management nurses. www.aspmn.org

Articles: http://www.painmanagementnursing.org/
Pain education- improving pain treatment through education: https://www.painedu.org/ Guidelines, tools, etc.
Pain educators: www.paineducators.org
ER/LA Opioid Analgesics REMS: https://search.er-la-opioidrem.com/Guest/GuestPageExternal.aspx
Pain Topics: http://updates.pain-topics.org/clinical_concepts/assess.php

C1. “Happy skin day!” - Carla Q. Anderson
How do we bring quality at the bedside?
How do we reduce hospital acquired conditions?
Do we know the condition of the skin of our clients/patients?
What assessment have we done?

“A Clinical Nurse Specialist implementing massage therapy in primary school to deal with problem behaviors”* Paul-André Gauthier
-Background: Over the years, primary schools have been challenged by the limited number of mental health nurses and psychologists who are available to help children who are having behaviors problems. By collaborating with registered masso therapists, we were able to implement a program that improves the behaviors of students and the class-rooms climate. Furthermore, too many children are waiting to be seen by health care professionals and the system cannot respond anymore to the growing demand.
-Subsequent to the integration of the program, the school director, teachers and parents were impressed with the behavior improvement of the children. The children learned how to recognise their negative feelings, requiring a time out that contributed to inappropriate behaviors in class or in school. The behavior improvement was also recognized at home as parents commented about the improvement in their children’s attitude and interactions.
-The success of this project in one school was immediate in one (1) month. The executive director of the regional school board asked that we collaborate to expand furthermore this project. We have identified from literature articles supporting the value of the program and we are looking to expand the project in other schools.

General Session – President’s state of the organization address
-How do we assist CNS in better remuneration and reimbursement? Advocacy.
-How do we promote the work of CNSs?
-The President went over their achievement over the past year. This information is available on the website www.nacns.org
-Also available, specialty papers. And specialty competencies –Sept. 2013.
-Need to increase their membership and revenue, new strategies are being developed and implemented. For example, webinars for CNSs.
-Goals for 2015-2020:
 ✓ Visibility.
 ✓ Authority – Education.
 ✓ CNSs bring evidence-based… at the bedside.
 ✓ Enhanced leadership qualities.
 ✓ Promote CNS research.

There is an APPs for the CNS Journal (i-pad).
Abstracts of this conference are published on the website: National Association of Clinical Nurse Specialists Annual Conference 2014; Orlando, Florida; March 6–8, 2014; Symposium Abstracts 2014


Friday, March 7, 2014
8:45 am NACNS Business Meeting
9:45 am Award Presentations: Student poster winner & affiliate of the year

General Session: “The CNS role in the big picture of primary care”* Jenny Richardson.
-What is leading the reform in health care? Funding.
-CNNS are connecting the dots.
-CNNS can improve health care services and at the same time reduce the costs by decreasing length of stay and readmission, and by improving patient outcomes.
-In doing culture change, CNSs can specialize in care co-ordination and transitional care.


D5: Clinical Management Lecture: “Reducing acute care heart failure readmissions from a skilled nursing facility”* Cindy Wetzel
-Assess the reasons for the readmission – e.g. not recognizing the Signs and Symptoms, non-compliance with the treatment plan with weight control, appropriate medication adherence plan, and diet, etc.
-Assess the learning and then the retention of information later.
-Follow-ups with telephone calls.
-Continuity of care will contribute to reduce readmission.
-Discharge order sets.
-It decreased their re-admission for CHF from 23% to 8%.

http://updates.pain-topics.org/clinical_concepts/assess.php
http://www.scopeofpain.com/tools-resources/
http://www.nacns.org
http://www.scopeofpain.com
http://painaction.com/
ER/LA Opioid Analgesics REMS: https://search.er-la-opioidrem.com/Guest/GuestPageExternal.aspx
Pain Topics: http://updates.pain-topics.org/clinical_concepts/assess.php
etc. Also, you can download APPs, for ex. opioid converter

Happy skin day
- Carla Q. Anderson

Paul-André Gauthier
E4: “Implementing evidence-based pain assessment: The impact to patient, nurse and system” (in paediatric care) • Angela Rowe
Parents may have an unrealistic expectation in regard to pain. They implemented a process to improve their services and then evaluated the outcomes.
TJC Audit Summaries (goal 90%):
- Outpatient:
  ✓ Screening being completed when appropriate: >90%
- Inpatient:
  ✓ Pain Assessed on Admission: >90%
  ✓ Pain Assessed q4 hours: >90%
  ✓ Pain Score recorded before each intervention: 89%
  ✓ Pain Score recorded after each intervention: 81%
  ✓ Appropriate pain scale used: >90%
Educated about pain, risk for pain, and effective pain management: 72%
They are working on:
- EBP implementation regarding pain scales and frequency of assessments.
- Increase in correct pain scale being utilized for patient.
- Increase in number of pain assessments initiated in a 24 hour period.

“Bringing evidence-based practice to inpatient pain assessment and management” by Cassia Chevillon
Free account on the internet:
with http://www.aapainmanage.org/education/
http://www.americanpainsociety.org/resources/content/apsresources.html
Apps available also. Ex. Timeline / etc.
CPOT (critical care) http://www.aacn.org/wd/practice/content/practicealerts/assessing-pain-critically-ill-adult.pcms?menu=practice
CNPI (for non-verbal) http://www.healthcare.uiowa.edu/igec/tools/pain/nonverbalPain.pdf

“24: A guide to inpatient pain management in the first 24 hours” • Kathryn Westman
“If you build, they will come: Reconstructing the role of the CNS” • Carole Wickham
Productivity model / Measuring outcomes through CNS competencies: a productivity model, by Vollman.
It is a very interesting document to read ***
The role of the CNS is key in improving the productivity.

“Development and utilization of a nursing intervention framework for clinical nurse specialist practice and role implementation” • Marcia Cornell
“As a clinical expert the CNS provides nursing care to patients that are at risk, they influence nurses and nursing personnel through evidence based practice, and works within the organization and system to achieve quality, cost-effective patient focused outcomes.”

CNS Driven campaign:
✓ Get’em Up & Get’em Moving
✓ Get’em Breathing
✓ Tight Glycemic Control
✓ Tight Volume Control
They develop a series of assessments and interventions for each aspect and then assess their achievement. They not only improve their outcomes, but they save $$.

“Impact of clinical nurse specialist practice council on role success” • Michael Urton
• Heather Shattuck
They formalize a CNS council, develop a charter, they help each other as CNSs, they became more effective, and they develop a more effective voice within their own organization.

Saturday, March 8, 2014
G4: “Improving the reliability of the discharge process for pediatric bone marrow transplant patients: An interdisciplinary team approach led by a pediatric Clinical Nurse Specialist and physician” • Nancy Tena
By being clinically ready. By being mentally ready.
By developing a business case to improve patient (and decrease their anxiety) and staff satisfaction (and improve their sense of accomplishment).
By reducing care failures.
By reducing unnecessary readmission.
By developing a Process Mapping.

“A CNS Team with a unified vision for excellence: Leading a quality caring initiative for patients receiving radiation via intracavitary pelvic implants” • Pamela Duncan • Tina Mason
For ex. In the sphere: Patients/ Clients:
Patient experience:
– Consistency of quality care;
– Hygiene and skin care;
– Dignity-quality of life;
– Pain management.
Family presence.
Patient education.
For ex. In the sphere: Nurses/Nursing Practice
Standardized order sets:
– Pre-op GYN Implant Orders
– PACU Admission
– Radiation Oncology Admission.
Safe and evidence-based nursing assessment and care;
Staff education;
Nurse satisfaction.
For ex. In the sphere: Organization/ Systems:
Obtained endorsement from leadership;
Advocated for resources;
Established new processes;
Updated skin integrity nursing standard.
“A Clinical Nurse Specialist studied the challenges of RNs working in oncology” • Paul-André Gauthier

-Background: Looking at challenges has never been studied as such and we were able to develop a model regarding the process that is been used to deal with challenges depending of the complexity of these. An innovative research is presented defining a challenge and identifying the various challenges that nurses face in oncology. Following the results of the inquiry, a model was developed regarding the steps used when dealing with challenges.

-Intervention: To discuss with patients the various health problems they experience when facing a terminal illness and enable them to understand what is going on. Also, to assist the family members and other health care professionals in developing a better understanding of the care required.

-Framework/Methods: A qualitative exploratory-descriptive study. During the collection of data, interviews were done with all participants using semi-structured questions. Then content analysis was accomplished using the strategies proposed by Miles and Huberman (1994) for qualitative data analysis.

-Findings/Outcomes: The challenges mentioned by RNs working in oncology were classified under four headings: those related to them, those related to clients/families, those related to health care professionals, and those related to management/government. For example: situations affecting nurses emotionally, ethical dilemmas, difficulty remaining in contact with clients, and lack of human resources.

-Implications: Nurses found that it is essential that a challenge remains a stimulating experience and an opportunity to excel in order to continue providing essential support to individuals faced with a terminal illness. More research is required to reveal challenges in other areas of nursing practice.

“Personal Essays for Admission to the MScN-PHCNP Program: Can They Predict Success?” • Jensen E. and Walkerley S. School of Nursing, York University, Toronto.

-Significance/Background: Nurses who apply to the MScN Primary Health Care Nurse Practitioner Program in the province of Ontario are required to submit an essay as part of their application package. The essay answers four specific questions about the understanding of the role of the Primary Health Care Nurse Practitioner and the qualities they bring to that role. Decisions about who will be admitted to the program are based in part on the answers the applicant provides in the essay. Review of the literature shows that generally there is limited data describing the significance of goal statements, what questions or topics ought to be addressed, and the relationship between the statement content and quality and the applicant’s ability to undertake graduate level nursing course work and clinical practice.

-Purpose: The purpose of this retrospective study is to explore the relationship between the content and the quality of applicant’s personal application essays and both their final grade for the summative course in the MScN-PHCNP Program at York University and success in becoming registered as a Nurse Practitioner in Ontario.

-Evaluation: In addition to analyzing the content of the essays and the scores they generate, descriptive data are also collected from the application files and analyzed in order to better understand all the variables that may best predict success in passing the RN-EC exam to become credentialed as a Nurse Practitioner in Ontario. All students who have completed the program since it started are included in the study.

-Discussion: Results will be available by March 2014. The results will add to knowledge of the validity of current admissions processes and assist in making revisions to these processes that will increase the likelihood that applicants who are more likely to be successful are admitted to the program. The findings may be useful for all graduate programs producing advance practice nurses.

“Closing General Session: The affordable care act and its implications for nursing” • Andrea Brassard

The CNS and RNs should practice to the full extent of their education and training.

We need to be more visible as CNS to make a difference. We need to mentor each other. Use evidence-based in our practices.

We need to work at removing barriers in our practices and we can do that. Get involved.

She suggested readings: ANA health economics; ACA compliant policy; at www.patientrights.org, etc.

About the Clinical Nurse Specialists: NEW!

Clinical Nurse Specialist Slides - Dr. Linda D. Urden (.ppt)
http://www.nacns.org/docs/CNS-NSNA-1211.ppt
Information — RNAO

Join RNAO & CNA (membership form) => in “my RNAO” section or on your membership renewal form. https://myrnao.ca/

CNA benefits:
- automatic membership in the International Council of Nurses (ICN);
- our flagship publication, Canadian Nurse, and its accompanying website;
- a reduced fee to CNA’s national nursing specialty certification program;
- free access to http://www.nurseone.ca/
- representation in CNA’s robust advocacy and policy advancements at the federal level;
- preferred rates on all CNA products and services, including the biennial convention and online continuing education courses;
- discounts on insurance and other affinity offerings; and
- so much more, with others being added all the time!

BPG on End-of-Life care: http://ltctoolkit.rnao.ca/resources/eol

BPGs: Become a Stakeholder Reviewer!
- Register on the website: http://rnao.ca/bpg/get-involved/stakeholder
- Suggest a topic: http://rnao.ca/bpg/get-involved/suggest-guideline-topic

RN-Journal:

All the interest groups: http://rnao.ca/connect/interest-groups

Political Action:
Areas of Focus:
http://rnao.ca/policy/issues

Article: on hip fracture.


BACKGROUND: Hip fractures are a common and serious consequence of osteoporosis, and hip fracture patients are at high risk for recurrence. Appropriate pharmacotherapy reduces this risk and is associated with reduced mortality after hip fracture, but a care gap exists for fracture prevention in these patients. This evaluation determined rates of osteoporosis treatment and bone mineral density (BMD) testing in hip fracture patients following discharge from a rehabilitation unit.

METHODS: A prospective cohort study of hip fracture patients aged ≥ 50 on an inpatient rehabilitation unit in 2008 and 2011. Patients were seen by a nurse specialist, and encouraged to see their family physician for further assessment and treatment. Physicians were sent a letter indicating the need to follow up with their patient. Patients were contacted following discharge from hospital to determine treatment rates.

RESULTS: Of 310 eligible hip fracture patients admitted to the rehabilitation unit in the years studied, 207 patients were reached post-discharge and provided data. Of patients who were not previously taking osteoporosis medication, 59% of patients from the 2008 cohort, and 42% of patients from the 2011 cohort had osteoporosis treatment initiated by six months following discharge. By 2 months following discharge, 46% of patients in the 2008 cohort had a new BMD performed or scheduled, while this was true for 14% of patients from the 2011 cohort. 35% of patients in 2011 had not seen their family physician by 2 months following discharge.

CONCLUSIONS: Rates for osteoporosis treatment and BMD testing were higher than those reported in the literature for patients not enrolled in case manager programs. BMD testing declined from 2008 to 2011. Lower treatment rates may be due to concerns regarding reports of possible association between bisphosphonate use and atypical fractures. Improving rates of patient follow-up with family physicians will be important for increasing hip fracture treatment rates after discharge.

CNS Annual General Meeting 2014

Registered Nurses’ Association of Ontario
L’Association des infirmières et infirmiers autorisés de l’Ontario

Clinical Nurse Specialist Association of Ontario
Association des infirmières et infirmiers cliniciens spécialisés de l’Ontario

New member of our Executive and Recipient of the CNS Student Award from York University: Kadeen Briscoe

CNS Association of Ontario 2014-2015
Executive members

Picture (from left to right):
✓ Paul-André Gauthier, Co-President & Director of Finance.
✓ Carmen Rodrigue, Director of Education and Membership.
✓ Elsabeth Jensen, Co-President.
✓ Carole Caron, Director of Communications.
✓ Kadeen Briscoe, New Member: CNS Student Representative (on the top picture above).

If you need to be in touch with us:
✓ ejensen@rnao.ca
✓ pgauthier@rnao.ca
✓ crodrigue@rnao.ca
Two (2) bursaries in the amount of $1,000 each will be awarded to a member of the CNS Association of Ontario who:

Is pursuing graduate education in nursing with a CNS stream (Master’s or PhD level) or
Will be attending an advanced practice nursing (CNS stream) conference in the coming year

AND

• Who is a current member of the CNS Association of Ontario (one year or longer);
• Who currently resides in Ontario;
• Who has submitted their curriculum vitae (including mailing address, telephone number and email address);
• Who has enclosed one letter of reference (from a peer or academic reference);
• Who has completed a short essay (not to exceed 500 words) on:
  ✓ Your professional objectives/ career goals (purpose for undertaking the program of study), and your potential contribution to advanced practice nursing.

Deadline: Monday, December 15th, 2014 before 1500 hours (3:00pm)
Submit to:

Elsabeth Jensen, RN, BA, PhD
Co-President,
CNS Association of Ontario

c/o Graduate Program Director,
School of Nursing,
Faculty of Health
Health, Nursing, and Environmental Studies Building (HNES), Room 325
York University, 4700 Keele Street, Toronto, Ontario M3J 1P3
Tel. (416) 736-2100, ext. 21023
Fax (416) 736-5714 (* please include a cover letter*)
e-mail: ejensen@rnao.ca

Application Process:
Please send your current curriculum vitae, one letter of reference (academic or professional), and a short essay of why you are deserving of this award to:

✓ The bursary will be awarded at the CNS Association of Ontario’s Executive — before the end January 2015.
✓ The person will receive a refund when the Director of Finance of the CNS Association of Ontario has received an official receipt and proof of successful completion prior to October 1st, 2015.