



**Oral Presentations  
CNS conference**  
**Thursday June 6, Friday June 7, 2019**  
St. Joseph's Healthcare Hamilton (West 5th Campus)  
100 West 5<sup>th</sup> Street, Hamilton, Ontario.



**Friday, June 7, 2019**

**08:15-08:50 Opening of the Clinical Nurse Specialists' conference day.**

**Section A -- 09:20-09:50**

**A/B 1 (1 hour) A discussion with CNSs on how to identify fears related to death when clients are facing a terminal diagnosis. Contact: Paul-André Gauthier.**

Paul-André Gauthier, Inf./ RN, CNS; PhD (nursing)  
Health Care Consultant – Expert conseil.  
Clinical nurse specialist (CNS) - Consultant in Nursing.

**Abstract**

In our undergraduate and graduate nursing programs, little is done in helping us learn on approaching topics such as death and dying and how to discuss these with clients, patients, and family members. In our clinical practice, little time is provided for educational session and not too many can facilitate such learning process and discussions.

Many CNSs and nurses remain frightened of talking about life and death concerns. So, these individuals are left with no one to help them deal with the fears they are facing. So, how can we help nurses as CNSs in improving their approach when individuals need to talk about their fears of death?

The goals with this presentation are to do an exercise of identifying fears and concerns of clients and how to address them, to gain confidence in discussing with clients, patients, and family members on various health concerns when they faced with a terminal diagnosis, and enable them to understand what is going on. Also, enable CNSs to assist them and other health care professionals in developing a better understanding of the care required and to feel more at ease when these discussions need to happen despite our discomfort. We can influence the care and demonstrate leadership in providing appropriate counselling regarding death issues when required (fears and concerns).

This approach has been presented at many workshops with health care professionals over the past twenty-five years. This is quite innovative to have an open discussion on fears of death with other individuals.

**A 2 Hope for recovery in mental illness: A nursing priority. Contact: Kelly Holt.**

Kelly Holt RN, BScN, MScN, Dilp. CBS, CPMHN(C)

**Abstract**

Hope is necessary to recovery in mental illness; without it, recovery cannot occur (Leamy, Bird,

LeBoutillier, Williams, & Slade, 2011; Mental Health Commission of Canada, 2015; McCauley, McKenna, Keeney, & McLaughlin, 2015). As frontline clinicians, nurses are optimally positioned to influence hope in their patients. The responsibility to promote hope in patients is communicated within the nursing literature; however, nurses' experience of operationalizing this need into practice has been little explored. This study expands on existing hope research through exploration of how nurses perceive the role of hope and their role in fostering hope in the recovery of persons with mental illness.

This study utilizes semi-structured interviews to explore mental health nurses' experiences of fostering hope in their patients with mental illness. The qualitative research method, Interpretive Description is employed to inductively conceptualize the experience of fostering hope. The results of this study indicate key interpersonal nursing interventions in the promotion of recovery in persons with mental illness, and describe the impact of systems and historical barriers to hope. Findings are discussed in relation to current theories of hope and hope-fostering interventions. Conclusions suggest building hope-fostering capacity in mental health nurses through education on specific hope interventions.

**Section B -- 10:00-10:30**

**A/B 1 (1 hour) A discussion with CNSs on how to identify fears related to death when clients are facing a terminal diagnosis. Contact: Paul-André Gauthier.**

**B 2 Development to results: The Clinical Nurse Specialist (CNS) role in the implementation of a sub-acute geriatric centre of excellence. Contact: Gina Dolezel.**

Gina Dolezel, RN, MN, NCA, GNC(C)  
Clinical Nurse Specialist (Geriatrics)  
Nurse Continence Advisor (NCA)  
GPA Certified Coach  
Primary Care, Rehab, CCC & Seniors' Services Program  
Credit Valley Hospital, Ontario.

**Abstract:**

The CNS role was implemented to support the implementation of a 20 bed Sub-Acute Geriatric program (SAGE) implementing best practices in care for the elderly and developing a centre of excellence for high risk seniors with sub-acute care needs and functional gain potential.

The CNS role improvement initiatives focused on supporting provincial guidelines set out in the Senior Friendly Hospital Strategy and the Assess and Restore framework and implementing various best practices guidelines in geriatric care.

Initial, and ongoing, initiatives by the CNS have included development of a geriatric learning series to the inter-professional team (IP), enhancing the dining and social experience, focus on toileting behaviours and routines and the adoption of the 48/6 model of care which includes understanding daily geriatric assessments, targeted interventions and development of individualized care plans. The CNS core competencies, as set out by the Canadian Nurses Association, was utilized to build an implementation and sustainability plan.

Since implementation on April 25<sup>th</sup>, 2016, outcome data has shown increase access to geriatric services, a reduction in length of stay, improved 30-day readmission rates for 65+ community dwelling seniors, increased access to geriatric services, improved functional independence measured using the National Rehabilitation Reporting System: FIM data and increased IP knowledge and skill in standards of care to the elderly.

The CNS role can assist in transforming delivery of specialized geriatric care, through facilitating enhanced knowledge to IP teams with geriatric expertise, adopting best practices in geriatric care in a designated unit and can show to have improved health outcomes for high risk seniors and well as improve access to care.

### **B 3 Guiding graduate students in the implementation of an Early Warning System (EWS) on a medical and surgical unit. Contact: Sonia Boccardi.**

Sonia Boccardi, Inf., MSc.Inf , CNCC (C)  
Conseillère-cadre en soins infirmiers-Chirurgie

Denise Bédard, Inf., MSc.Inf  
Conseillère-cadre en soins infirmiers-Chirurgie

Marineh Carapetian, Inf., MSc.Inf , ICMC(C)  
Conseillère-cadre en soins infirmiers-Médecine

Centre intégré universitaire de santé et de services sociaux du Centre-Ouest-de-l'île-de Montréal/  
Hôpital Général Juif.

#### **Abstract**

Quality improvement (QI) projects, such as those targeting practice change, are not always easy to implement in our current healthcare system. Health care institutions are constantly striving to improve the methods by which hospitalized patients are monitored and assessed, with an ultimate goal to reduce the failure-to rescue and code blue situations. Constraints such as time commitment, human resources, as well as financial limitations have been identified as barriers towards the implementation of QI initiatives.

Clinical Nurse Specialists (or *Conseillère-Cadre in Québec*), are expert clinicians whose role is to monitor quality of care, be champions of evidence-based practice, educate, consult, and be interprofessional team leaders in the provision of safe, quality care.

At the Integrated Health and Social Services University Network for West-Central Montreal (Jewish General Hospital), we partnered with the McGill University Ingram School of Nursing's graduate program, over the last two years, to design, implement and evaluate a knowledge translation (KT) project on early warning systems (EWS). Early warning system (EWS) scores are used by healthcare providers to recognize early signs of clinical deterioration in a patient and trigger more intensive care such as increased nursing monitoring, informing the treating physician, or activating the code blue team. We acted as facilitators for the students in navigating through the different stages of project development, from contacting physician partners and nursing leadership, and through the approval process of official documentation. This KT project is presently being piloted on an internal medicine unit and a post-surgical unit.

#### **Section C -- 10:50-11:20**

### **C 1 Delirium prevention in acute care: The role of the CNS in implementing an evidence-based process improvement project. Contact: Yasmin Khalili.**

Yasmin Khalili, RN, BScN, MScN, CWS1 (Presenting),

Alex Curkovic, RN, BScN, MN, GNC (C) 1,2;  
Caroline Mavrak, RN, BScN, MEd, ONC(C) 1,  
Jennifer Kodis, BSc(HK), MHSc(HA) 1;  
Leslie Gillies, RN, BScN, Med 1,  
Denise Bryant-Lukosius, RN, PhD 1,2.

1- Hamilton Health Sciences.

2- McMaster University.

### **Abstract**

**Objective:** To highlight the role of the CNS as it operates within the domains of influence, meeting the needs of older population and promoting safety and evidence based-practice

**Issue:** Delirium is an acute disorder of attention and cognition in the older adult, usually occurring after acute illness, surgery, or during hospitalization. Although common, and often fatal, it is frequently underdiagnosed, with serious adverse effects on the individual's function and quality of life, as well as broad societal effect with substantial health care costs.

As the aging population continues to grow, older adults have become the highest users of health care and are therefore at highest risk of hospital acquired delirium. The literature consistently points out that delirium, though complex, may be prevented by screening high risk patients and by working together with interprofessional team and implementing multi-component system-wide interventions. As a potent indicator of patients' safety, delirium provides a great target for a system-wide process improvement.

The CNS role is key in bridging the gap between research and practice and promoting best safe practice as it operates in its different spheres of influence (patient, nurse, system). This work is however often invisible and therefore overlooked at times within healthcare institutions.

**Project and discussion:** Through an evidence-based process improvement project the CNSs in the HELP program, co-lead a delirium screening accuracy project with use of staff champions and education specialists to implement and improve delirium screening accuracy in acute care setting. Barriers and enablers to implement and support the work of the CNS will be discussed.

### **C 2 Impacting pediatric pain management: Diverse Clinical Nurse Specialist roles in pain care. Contact: Jennifer Tyrrell.**

Lorraine Bird, RN, MSc  
Geraldine Cullen-Dean RN, MN;  
Lisa D' Alessandro, RN, MN;  
Jacqueline Hanley, RN, MN;  
Jennifer Tyrrell, RN, MN.

### **Abstract**

It is estimated that 77% of hospitalized children in Canada experience procedural and disease-related pain during hospital admission (Stevens et al., 2011). Of those many will go on to experience prolonged pain after discharge home. In addition, 25% of all children experience chronic pain at some time in their childhood (Rabbitts et al. (2017). The need for comprehensive and focused pain management strategies has led to the expansion of advanced practice nursing roles across the care continuum. Clinical Nurse Specialists promote excellence in nursing practice and are well positioned within multidisciplinary teams to use specialized knowledge and skills, problem solving, and clinical experience to provide solutions for

complex pain issues. This presentation will describe the unique roles of five Clinical Nurse Specialists supporting children and families with acute, transitional and chronic pain needs both in inpatient and outpatient settings.

We will describe our innovative service delivery model that ensures continuity of care by providing flexibility in service delivery, seamless communication strategies, and the integration of evidence in the development of clinical guidelines and protocols. Our distinctive roles in direct clinical practice, advocacy and leadership will be illustrated through a case study. Finally, we will describe our contributions to the advancement of children's pain care at local, provincial, national and global levels.

Rabbitts et al. (2017). Prevalence and predictors of chronic postsurgical pain in children: A systematic review and meta-analysis. *Journal of Pain*.

Stevens et al, (2011) Epidemiology and management of painful procedures in children in Canadian hospitals. *CMAJ*, April 19;183(7).

#### **Section D -- 11:30-12:00**

#### **D 1 Clients with mental health issues & life limiting illnesses: The art & the science of caring. Contact: Mary-Lou Martin.**

Mary-Lou Martin RN, MScN, Med.

#### **Abstract**

This presentation will describe caring for clients with a mental health issue and a life limiting illness. The life expectancy of mental health clients is 15-20 years shorter than the general population. Clients with life limiting illnesses have the right to quality palliative care. Unfortunately, many clients are disadvantaged by stigma, poverty, lack of autonomy and reduced social networks. Mental health nurses often feel unprepared to meet the needs of clients with a life limiting illness. Clients need palliative care to be introduced earlier in their care experience

A therapeutic relationship between the nurse and the client (with a life limiting illness) and their family is paramount. The myths about palliative care will be debunked. Trajectories of dying, palliative care and a prognostic indicator guide will be described. A holistic framework for client assessment and evidenced-based tools to assess symptoms and functioning will be introduced.

Prevention, early identification, assessment and treatment of clients' life limiting illnesses can sometimes be challenging. Anticipation of clients', families' and nurses' needs is extremely important in the care process.

Strategies including timely and open communication, clarifying goals of care, reaching out to experts for consultation and support, debriefing with the team, reflective practice and engaging in self-care promote quality of care and satisfaction with care.

Educating mental health nurses about palliative care can enhance knowledge, skills and confidence. Providing a palliative care approach to clients who have life limiting illnesses translates to better coordinated care and improved quality of life for clients and families.

#### **D 2 Enriching care for Gitksan First Nations with dementia through culturally relevant, place-based learning. Contact: Gina Gaspard.**

Gina Gaspard RN MN CNS healthy living, chronic disease, end of life

Debbie Sullivan RN MN community health nurse

Mavis Sebastian RN BSN community health nurse

## Abstract

This research project led by two point of care nurses and a CNS used participatory action research design. We engaged community members from two Gitksan First Nations communities in Northern British Columbia along with nursing teams (registered nurses, licensed practical nurses and care aides) working at the local hospital and in the First Nations communities. Data was gathered through a mixed method approach that included knowledge tests, semi-structured focus groups and one-to-one interviews.

Guided by the principles of place-based learning, Indigenous knowledge was woven into a three-day workshop for nurses. The education was unique because there was a shift from the western medical model towards an emphasis on community wellness and compassion using an Indigenous lens. Through engagement of the community as partners early in the project, a balance was achieved between individual versus community and western versus traditional First Nations perspectives. Although this strategy could be applied to a number of health issues, the communities requested a focus on dementia.

Dementia refers to a collection of diseases which not only have serious effects on the individual and family but also on society. The emotional and financial cost of caring for individuals with dementia can be an extreme burden. Rates of dementia in First Nations peoples of Canada are equal to or higher than they are in non-Indigenous people and these numbers are expected to increase (Hulko et al., 2010; Jacklin & Walker, 2012), as the life expectancy of First Nations people increases.

### **Plenary session - Team presentation 12:45- 13:45**

#### **E 1 Clarifying specialized and advanced nursing roles: Results of a national study to inform nursing workforce optimization in Canada. Contact: Denise Bryant-Lukosius.**

Josette Roussel RN MSc MEd,  
Marcia Carr RN MS GNC(C) NCA,  
Krista Jokiniemi RN PhD,  
Ruth Martin-Misener NP PhD,  
Joan Tranmer RN PhD,  
Kelley Kilpatrick RN PhD,  
Sarah Rietkoetter BA BHSc, and  
Denise Bryant-Lukosius RN CON(C) PhD

## Abstract

**Goal:** To identify and compare the deployment, practice patterns, and competencies of SN, CNS, and NP roles to discern their unique contributions to healthcare.

**Problem:** Collaboration among specialized nurses (SNs) in non-advanced roles, clinical nurse specialists (CNSs), and nurse practitioners (NPs) is necessary for quality healthcare. The lack of role clarity and paucity of research evidence to support healthcare decision-making are barriers to the effective use of these roles.

**Methods:** A descriptive cross-sectional study employed an online questionnaire involving a validated tool to assess domains of advanced practice. Participants had to be working in a clinical role and be: a) registered nurse with a diploma/baccalaureate degree in nursing and specialty certification, or a CNS or NP with a master's/doctorate degree, and b) able to complete the questionnaire in English or French. Recruitment occurred through national specialty and advanced practice nursing organizations.



**Results:** Participants included SNs (n=576), CNSs (n=345), and NPs (n=526). More SNs (59%) and CNSs (64%) worked in hospitals compared to NPs (37%) (p=0.000). Overlap in job titles was noted, with 61% of CNSs working in a CNS titled position. All groups were most involved in direct comprehensive care but differences and overlap in activities were observed. CNSs spent more time in non-clinical domains compared to SNs and NPs. Role type, years of CNS/NP experience, and certification modestly predicted involvement in practice domains.

**Conclusion:** New insights into the unique and complementary contributions of SNs, CNSs, and NPs are provided and inform recommendations to effectively utilize CNS roles in Canada.

**Section F -- 14:10-14:40**

**F 1 How can a CNS discuss sexuality with clients/ patients when they face concerns or diseases affecting their sexual organs? Contact: Paul-André Gauthier.**

Paul-André Gauthier, Inf./ RN, CNS; PhD (nursing)  
Health Care Consultant – Expert conseil.  
Clinical nurse specialist (CNS) - Consultant in Nursing.

**Abstract**

During our preparation in nursing schools, little details were given on how to assess and discuss concerns related to sexuality. Some nurses feel uncomfortable or it may be to taboo to even approach this subject as such. Sexuality is healthy and is part of our human nature. CNS should not be embarrassed discussing sex with clients / patients.

When they are facing a health problem regarding their sexual organs such as cancer (e.g. breast, uterus, prostate, testicular), infection of sexual organs (e.g. gonorrhea, syphilis or other STD/ STI), or disease (such as HIV or hepatitis, or a heart attack), we need to initiate the “sex topic” and discuss concerns related to the sexuality. Clients/ patients may require discussing how to approach the topic with their sexual partner. They may be experiencing discomfort or other symptoms that render intercourse painful. The clients’ health or diseases have a big impact on their sex life and vice versa. Seize the moment and the opportunity, be direct, consider the person’s point of view when looking at options, move beyond facts, talk about feelings, and safer sex.

This approach has been presented numerous times at conferences or workshops. I have learned over the years that we can influence the care and as CNS we can display leadership in providing appropriate counselling regarding sexuality when required. This is quite innovative to have an open discussion with clients/ patients despite their various culture and background.

**F 2 Smart technology in community homes and transitional hospital apartments for individuals with mental illness. Contact: Cheryl Forchuk.**

Cheryl Forchuk RN PhD  
Abraham Rudnick MD PhD  
Deborah Corring PhD  
Jodi Younger MAsc MSc  
Lisa Van Bussel MD  
Naghmeh Mokhber MD  
Sujata Ojha MD  
Puneet Seth MD  
Jeffrey Reiss MD

## Abstract

**Objective** The objective of this study is to evaluate the use of smart technologies in community homes and in transitional hospital apartments.

**The Problem** Many individuals experiencing mental illness remain on hospital inpatient wards or are readmitted because optimal care in the community is not always available.

**Method** This pre-post study is recruiting 13 participants in community homes and 20 participants in transitional hospital apartments (aged 18-85). Wireless health monitoring devices such as weigh scales, blood pressure monitors, glucometers, and heart-rate activity monitors will be offered as needed. Automated medication dispensers will be available to participants in community homes. All health device data will be exported to the Lawson Integrated DataBase which health care providers can access and monitor.

Participants can choose screen devices such as smartphones, tablets, and/or touch-screen monitors. These will provide video-conferencing capabilities and prompts/reminders based on care plans. Participants will also use the screen devices to complete assessments and mood monitors via the Collaborative Health Record software. Completed assessments are sent to their health care providers.

Participants in the transitional hospital apartments will complete a semi-structured interview upon discharge and at 6-months follow-up. Participants in community homes will complete interviews at baseline, 6-month and 12-month follow-ups.

**Results** The findings from this study could inform policy and decision-makers towards adopting smart technologies into the spectrum of mental health care.

**Conclusion** It is anticipated that participants will demonstrate enhanced levels of community integration, improve housing stability, and greater independence in self-care for chronic mental health and physical illnesses.

## **F 3 Partners in care using a model of self-management: Individuals living with schizophrenia & outpatient case managers. Contact: Mary-Lou Martin.**

Mary-Lou Martin RN MScN MEd  
Susan Strong, PhD, OT Reg. (Ont.) (C)  
Heather McNeely, PhD, C. Psych  
Alycia Gillespie, MSW, RSW  
Lori Letts, PhD, OT Reg. (Ont.) (C)

## Abstract

Individuals/families living with schizophrenia told us they are insufficiently involved in the treatment process. Poor insight and negative symptoms often lead to disengagement, nonadherence, relapse and rehospitalisation. Families and providers are challenged to maintain relationships and access interventions with someone who, may not believe they have an illness requiring treatment.

Self-management (SM) support is an effective intervention for engagement and building capacity within individuals/families. A model of SM support (*SET for Health*) is being developed and embedded into outpatient case management care. A mixed method feasibility study is examining to what extent this model: adds value from clients'/families' and providers' perspectives; and influences individuals' engagement in SM, treatment, symptom distress, hope and quality of life.

Ten managers are offering the intervention to 42 individuals to-date. A continuous learning process informs



delivery and evaluation. Findings reveal: expanded spaces for client participation, client voice and engagement; SM discussions of illness/health; and provider recovery orientation.

Highlighted were provider variations in delivery and challenges providers experienced changing traditional practices. Results can be understood in the context of a new practice being delivered by various health disciplines. The role of the CNS in this project will be described.

The process contributes to a culture of client/family/provider self-reflection, learning and the resetting of expectations. Lessons learned include: SM support can be delivered and benefit clients/families; supporting client participation increases engagement; partnership involves autonomy and responsibility; the importance of providers believing in SM; a SM approach can continue during crises; and tools can promote SM reflection and learning.

## **Section G -- 15:00-15:30**

### **G 1 Utilizing technology- enhancing the CNS role & improving patient outcomes: A win win strategy. Contact: Rashmy Lobo.**

Rashmy Caroline Lobo RN BSN, MSN

#### **Abstract**

**BACKGROUND:** The incidence of Heart disease and subsequent procedures such as Cardiac Angioplasty is growing rapidly. Poor adherence to prescribed treatment regimens by patients can compromise outcomes. Patient centered cardiovascular health education is likely to improve the shortcoming. The Clinical Nurse Specialist describes a proactive cardiac education innovation-intervention strategy implemented.

**METHODS:** In this interventional study CNS integrated using Information Technology and Mass communications approach to deliver information related to Pre-procedure expectations, Intra-procedure vignettes and Post-procedure discharge instructions. IPads were used to showcase vignettes to the Procedure unit which were recorded and disseminated. Sampling included all prospective clients presenting to the unit prior to the Angiography or Angioplasty. Online access was available using the Hospitals Web home page. Exam builder tools were utilized to assess knowledge retention and comprehension after each recording. Reinforcement to online educational information was provided with Guides to Angiography / Angioplasty containing and links to Online Vignettes.

**RESULTS:** Access to Online education at home prior to procedure was at 75 % pre-procedure, where as in unit access was at 100%. Statistically significant knowledge increase was observed in post-procedure expectations (88% to 100%). Clients were followed thru their journey post discharge with visits to their first follow-up up clinic visit, subsequent cardiac rehab pathway. No recurrence for stent thrombosis or readmission within the 30 days of discharge post procedure and compliance with the DAPT treatments were assessed and found to be within the 98%. Reduced Post-procedural complications and adherence to treatment regimen were significant.

**CONCLUSION:** Integrating innovation within the CNS role and carefully designed educational programmes have the potential to produce desired patient outcomes such as reduced procedure anxiety, adherence in patients with treatment options such as cardiac rehabilitation or compliance to anticoagulants.

### **G 2 Short-term assessment of risk and treatability (START): Development by CNS & colleagues. Contact: Mary-Lou Martin.**

Mary-Lou Martin RN MScN MEd

## **Abstract**

This presentation will provide an update on the developments and research findings with the Short-Term Assessment of Risk and Treatability (START) and the Short-Term Assessment of Treatability: Adolescent Version (START: AV). These guides have garnered considerable national and international attention.

Nurses and other clinicians are involved in the challenging clinical task of assessing risks, and developing a plan to manage and/or reduce risks. The START and the START: AV provide for the dynamic assessment of multiple risk domains (START: violence to others, suicide, self-harm, being victimized, substance use, unauthorized absences and treatability & START: AV: violence, non-violent offenses, substance abuse, unauthorized absences, suicide, non-suicidal self-injury, victimization, health neglect). START and START: AV are unique because they assess both strengths and vulnerabilities, while allowing for the assessment and documentation of case specific risk factors and risk formulation. The measurement of factors affecting the multiple risk domains, the identification of signature risk signs and risk specificity statements will be discussed. Connections between the START and START: AV and evidence-informed practice will be explored and discussed.

Research on the validity, reliability and utility of the START and START: AV will be described. The START and the START: AV offers a structured professional judgment approach to assessing strengths, vulnerabilities, and multiple risks with persons in hospital and community settings who are receiving mental health and/or forensic services. The role of the CNS in the development and the evolution of the START guide will be highlighted.

## **G 3 Intermediate care training program: Impact on the nurse's clinical judgment and patient safety. *Contact: Marineh Carapetian.***

Marineh Carapetian, B.Sc.(N), M.Sc.(N), CMSN(C)  
Clinical Nurse Specialist in Medicine & Chronic Illness  
Conseillère-cadre en soins infirmiers-Chirurgie  
Centre intégré universitaire de santé et de services sociaux du Centre-Ouest-de-l'île-de Montréal/  
Hôpital Général Juif

## **Abstract**

Growing patient acuity increases the complexity of the care required. On a medical clinical teaching unit, beds are now dedicated for patients whose acute conditions require more care and monitoring than the average medicine patient. However, the creation of these intermediate or “high intensity” care beds creates a need for nurses to acquire specific knowledge and develop skills to care for this population. To this end, a teaching program for nurses to care for patients in this specific care setting has been developed at the Integrated Health and Social Services University Network for West-Central Montreal (Jewish General Hospital). Centered on evidence-based practice, the program was created to ensure the physical and mental health assessments of the acute patient and the timely implementation of appropriate nursing interventions. The modules are intended to promote the clinical judgment and critical thinking of nurses to ensure safe and quality care. Following the training, participants say they are better equipped to care for patients and report better communication with the medical team.

The presentation will describe the process of developing and deploying the training, including the content and teaching activities that make up the learning modules. In addition, we will discuss the strategies used to

evaluate learning outcomes after the training as well as the sustainability of the knowledge translation.

## **Section H -- 15:40-16:10**

### **H 1 Articulating how the role of a Clinical Nurse Specialist contributes to optimal health care outcomes: A logic model approach. Contact: Alex Curkovic.**

Alex Curkovic, RN, BScN, MN, GNC (C) 1,2;

Yasmin Khalili, RN, BScN, MScN, WCS 1;

Jennifer Kodis, BSc(HK), MHSc(HA) 1;

Elaine Principi, BHScPT, Med 1;

Charissa Cordon, RN, MN, EdD 1,2;

Denise Bryant-Lukosius, RN, PhD 1,2.

1- Hamilton Health Sciences.

2- McMaster University.

#### **Abstract**

**Introduction** - Clinical Nurse Specialists (CNSs) play a key role in supporting older persons throughout their health care journey. Lack of clarity on how CNS activities connect to organizational goals and clinical priorities can make the role vulnerable. Recognizing this, the CNSs in the Hospital Elder Life Program (HELP) set out to identify structures, processes, and outcome indicators that describe the impact of CNS' practice on hospitalized older persons in concert with organizational strategy.

**Main Thesis** - CNS and other Advanced Practice Nursing (APN) roles have been implemented nationally in acute care settings. Some of these roles have been eliminated due to fiscal constraints. As part of a larger project designed to build the capacity of APNs to lead the development and evaluation of their roles, the HELP CNSs set out to clarify and define their role in delirium prevention. Using small group learning and participatory approaches, the CNSs developed a logic model to articulate their role. Through team meetings; inputs, role specific activities, outputs, outcomes, and impacts of the CNS role were determined. The logic model was aligned with the corporate strategic plan, the Quadruple Aim Framework and the Institute of Medicine's Six Domains of Health Care Delivery to refine short, medium, and long-term outcomes.

**Conclusion** - Utilizing a logic model approach is an effective way to clearly articulate the CNS role and obtain the buy-in of key stakeholders. Defined CNS outcomes and associated metrics inform evaluation planning and illustrate the potential impact of the role.

### **H 2 Breaking the cycle from hospital to homelessness: Innovative housing first initiative.**

**Contact: Cheryl Forchuk.**

Cheryl Forchuk RN PhD

Jeffrey Reiss MD, London Health Sciences Centre (LHSC)

Sherri Lawson, Director, Inpatient Mental Health, London Health Sciences Centre (LHSC)

Ann Turcotte, Director of Family Medicine, University Hospital (LHSC)

Tim Rice, Director of Family Medicine, Victoria Hospital (LHSC)

Dean Astolfi, Canadian Mental Health Association Middlesex

Nedrita Shemshedini, Canadian Mental Health Association, Middlesex

Dan Cantuto, Ontario Works

Charlotte Dingwall, Salvation Army Centre of Hope

#### **Abstract**

The project seeks to evaluate the effectiveness of preventing homelessness by reducing hospital discharge to

“no fixed address”. Little is known about this issue or how to intervene. Homelessness has a detrimental effect on recovery from physical and mental illness. This intervention redesigns and streamlines delivery of services by establishing housing and income supports within hospital medical wards. Earlier work utilizing this strategy was successful in reducing discharges to homelessness from psychiatric wards. Local shelter data indicated an increase in discharges from medical units to homelessness, as similar discharges to homelessness from psychiatric units decreased. Preliminary data has shown that people at risk of discharge to homelessness from medical units often have complex co-morbidities, which include other physical as well as mental health diagnoses. Moreover, the typical length of stay is shorter than in psychiatric units, leaving a smaller window for intervention. Notwithstanding, the majority of people referred to the program were discharged to housing rather than homelessness.

Preliminary data shows that 34 individuals have obtained housing while 27 have been discharged to no fixed address. This innovative intervention is novel in its delivery and in establishing new partnerships with medical wards at hospitals. Canada lacks a coordinated and evidence-based approach to discharge for individuals who are experiencing, or are at-risk of, homelessness. This housing first initiative represents a potential best practice strategy with direct implications for critical nursing specialists, health care delivery and the wellbeing of individuals and communities.

### **H 3 Understanding compassion in mental health care from the perspectives of culturally diverse patients and families. *Contact: Elisabeth Jensen.***

Elisabeth Jensen, RN, BA, PhD  
Rani Srivastava, RN, PhD,  
Ann Pottinger, RN, MN,  
Nicole Thompson, Reg. OT, PhD,  
Nadia Green, RN, MN,  
Sean Patenaude

#### **Abstract**

Compassionate care is considered a fundamental characteristic of quality care. The need for compassion in care is not new, however understanding compassion and, translating the knowledge into action, remains a challenge. Few studies have focused on patient and/or family definitions of compassion or assessed outcomes in relation to desired health outcomes. This gap is even more significant in mental health. Another major gap in the current literature on compassion is a lack of discussion of how culture influences the understanding, enactment, and expectation of compassion. While the dominant culture is Caucasian, two population groups are more prevalent in the population of people with mental illness than in the general population and need to have voice. These are indigenous people and people with African heritage. To understand the similarities and differences in the meaning and experience of compassion in care these voices must be included. The study examines how compassion is experienced and understood by patients and families in a mental health context and explores if and how the understanding and experience of compassion varies across culturally diverse or racialized groups.

Interpretive Descriptive design, using stratified focus groups will be used to address the knowledge gap identified by answering the research questions. By improving the ways compassion is understood and experienced by patients and families can guide health care providers to personalize care delivery. The study is currently underway.