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

Newsletter

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In this issue:

From the President

CNS-ON

Lack of Distinction Between Post-RN Specialty and Graduate-Level Advanced Practice.

At a glance, it's easy to see how the term certification can lead to confusion, especially when it's used to describe both post-RN or post-RPN/LPN credentials and advanced-level designations. In practice, this blur still happens often. A nurse might be certified in a specific area of care, but that doesn't automatically mean they're considered a specialist in the advanced practice sense. There's a clear distinction between being certified at an entry or practice-enhancement level and holding a graduate-level designation as a Clinical Nurse Specialist (CNS) or Nurse Practitioner (NP). The two are not interchangeable, and yet, in many clinical settings, this difference remains misunderstood.

Often, we notice that there is no acknowledgment of the difference between post-basic certification and graduate-level advanced practice certification (e.g., CNS or NP), which confuses people who may assume all certifications are created equal. However, the post-RN certifications are not advanced practice certifications but clinical certifications typically available to experienced RNs without requiring graduate education.

In Canada, post-licensure certification in areas such as critical care, oncology, gerontology, or community health, offers practicing nurses a way to confirm their clinical expertise. However, these credentials differ significantly from graduate-level advanced practice roles such as Clinical Nurse Specialists or Nurse Practitioners. While valuable, these certifications are distinct from graduate-level roles of CNSs or NPs, which require advanced education and broader scopes of practice and involve expanded roles in diagnosis, treatment, leadership, and systems-level thinking. Both types of credentials support quality care, but they represent different levels of clinical and professional preparation.

There are discussions about these differences at the provincial and national levels. I hope it helps to bring some clarity.

Sincerely,

Paul-André Gauthier. President CNS-ON.

The "Staying Power" of CNSs

Fifteen years ago, Bryant-Lukosuis (2010) forewarned the health care and nursing communities of two events that would impact the retention and sustainability of CNS practice and health outcomes for Canadians. The first event was a decrease in the number of practicing CNSs (Jokiniemi et al., 2023; Kilpatrick et al., 2013; Splane et al., 2023). The second event, impacting the number of practicing CNSs, was a decrease in the number of courses and programs to prepare CNSs (Bryant-Lukosuis, 2010; Martin-Misener et al., 2010). However, with this warning, Byrnat-Lukosuis (2010) identified that CNSs were distinguished with a unique quality of "staying power" (p. 20) that had been maintained for forty years. Despite being quantified as only "some," the "staying power" of the declining numbers of CNSs has been effective enough to maintain CNS practice, research, and education as well as prepare and maintain future CNSs, in spite of our lack of title protection.

In 2013, Kilpatrick and colleagues found that nurses who reported being a CNS had between 0-36 years of practice experience. The range in practice experience suggests that the "staying power" of CNSs was effective as some CNSs (< 8 years) were introduced to practice, some CNSs were experienced (8 years) and other CNSs had longer times in practice. Kirkpatrick et al. (2013) identified that 65% of CNS were prepared with a Master's degree. This suggested that the commitment to CNS practice was weighted heavily enough that CNSs received not only the necessary academic preparation to practice, but also support to maintain their practice within healthcare settings (Martin-Misener et al., 2010). Although details about the focus of graduate courses to prepare CNSs were not explored, Martin-Misener et al. (2010) argued that APNs required knowledge about engaging in research, utilizing evidence, specialized and advanced knowledge in nursing theory, practice, clinical care and education, and practice time in clinical placements to utilize and apply their clinical knowledge with faculty and preceptors.

Martin-Misener et al. (2010) highlighted both the necessity and areas that CNSs required advanced knowledge and practice in as well as how CNSs use of knowledge differs from other APNs. Expanding the findings of Martin-Misener et al. (2010), Jokiniemi et al.'s (2023) pointed out that CNSs' (n=221) activities were closely balanced across all five domains: a) direct comprehensive care (2.74 (0.70)), b) system support (2.70 (0.83)), c) education (2.66 (0.84)), d) leadership (2.10 (1.20)), and e) research (2.00 (0.98)). Perhaps the balance across these practice domains contributes to CNSs' uniqueness and "staying power" in the current health care system.

To ensure that CNSs' "staying power" is sustained and maximized within the current health care context, it is imperative that we have knowledge about what is currently offered in academic programs. To do this, we may wish to explore both the educational programs and courses that are available and how these courses prepare CNSs for practice. Having knowledge about the current local and national academic context would assist us to better understand how CNSs are currently prepared and what next

steps need to be taken with our academic partners to maintain and sustain the academic preparation of CNSs for practice.

Sincerely,

Robin Coatsworth Puspoky, RN, PhD
Workplace Liaison (ENO)

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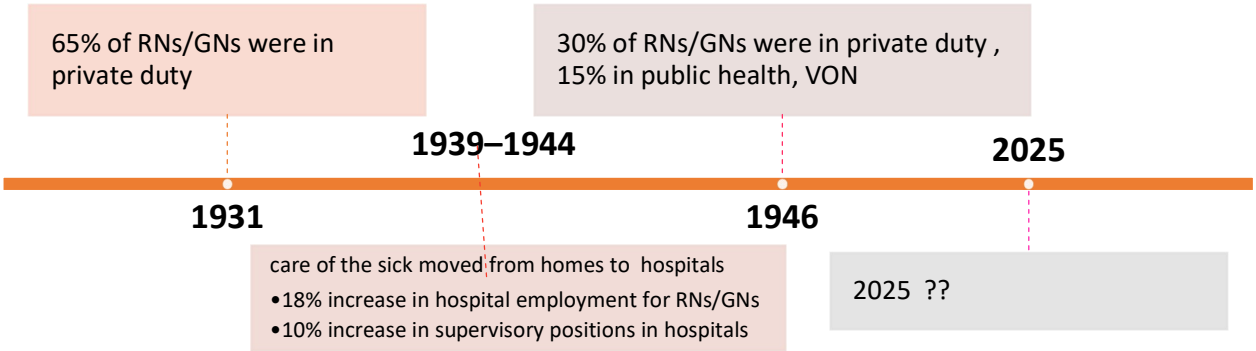
Musings on the History of Nursing

Recently, I gave an address to the Canadian Association of Self-Employed Regulated Nurses who were interested in the topic “How do independent practice and health care related legislation intersect?". The preparation took me back to some information in the Canadian Nurse Journal that I had read some years ago.

In a presentation given to the Canadian Nurses Association in 1946, Charlotte Eastwood noted that nurses were moving from private practice to employment in hospitals. Her report was published (CNJ, 1946) and is summarized in the table below. At that time there were some nurses who were working as Graduate Nurses (GNs) while a growing number of nurses were Registered Nurses (RNs).



We often forget that nursing in the country started as an independent practice, just like medicine. The only graduate nurses who worked in hospitals were head nurses, supervisors, and the chief nurse. The work was done by nursing students. Hospitals would offer women a two-year program of nursing education in the hospital, after which they would go out in the world to make their own way. It was a nursing shortage during the Second World War that led to a campaign encouraging people to go to hospital for care so that the remaining nurses could be spread further, having more than one in home patient to look after. This was also the time when the role of nursing assistant was developed in Ontario so that the nurse could take on more patients.

Over time, the number of nurses in positions as employees grew. Nursing education and often regulations as well, are tailored to prepare nurses to be both professional and employees. A good employee does the job the employer designs which may conflict with the expectations of the nurse as a professional who is the expert on their own skills and expertise. This extends to the realm of clinical specialists.

As a Clinical Nurse Specialist, I have seen employers redeploy CNSs to units that are not compatible with their expertise. This does not happen to physicians. A cardiologist would not be redeployed to rheumatology units but a CNS in pediatrics can be reassigned to gerontology. Think about that for a few minutes.

Has the preparation to become a professional been overshadowed by the preparation to become an employee? Are there times we do not speak out for fear of losing our job, even if it compromises patients? Would we be having conversations about nurses practicing to full scope if employers were not designing nursing jobs?

I call on all of us to reflect on how we see the future of nursing. Do you see yourself as a professional first or as an employee first? How does that shape your engagement with nursing, the public and health care?

Sincerely,

Elsabeth Jensen, RN, BA, PhD (Nursing)
Member-at-Large

Whitton, C., (2014). The nursing profession and the evolution of Public Social Services. *Canadian Nursing Journal, 42* (10), (pp. 861-866). Ottawa: Canadian Nurses Association.

Nursing Specialization and Clinical Nurse Specialists

Over the past several decades, health care has been transformed by advances in specialization, both in medicine and in nursing. These developments have expanded the boundaries of practice, led to groundbreaking research, and produced measurable improvements in survival, quality of life, and system efficiency. To consider where we would be as a society without these changes is to imagine a health system that is less responsive, less effective, and less able to meet the complex and diverse needs of today's populations.

Equally transformative has been the growth of nursing specialization over the past forty years, particularly the role of Clinical Nurse Specialists (CNSs). These highly educated nurses bridge the gap between evidence and practice, bringing advanced clinical expertise, leadership, and research translation into every corner of the health system. Without their evolution, nursing would have

remained largely confined to generalist roles, with limited authority to assess, manage, or lead in complex environments. Individuals with multifaceted conditions would be left without the benefit of CNS expertise, relying solely on physicians in an already overstretched system.

The Role of Medical Specialization

If the past twenty years had not witnessed the remarkable expansion of medical specialization, the health outcomes of individuals and populations would be markedly poorer, and our health systems would be under even greater strain. Specialization has enabled a shift away from generalized, one-size-fits-all approaches toward evidence-based, targeted interventions that are safer and more effective. Without this progress, many of the conditions now treatable or manageable, ranging from advanced cancers to cardiovascular disease, would still be associated with high rates of disability, mortality, and suffering.

Clinical Consequences of Medical Specialization

Oncology provides one of the clearest examples of this transformation. The introduction of precision therapies, immunotherapies, and minimally invasive surgical techniques has significantly improved survival and reduced treatment burdens. Similarly, progress in cardiology, particularly interventional procedures and preventive strategies, has extended life expectancy and lowered the incidence of catastrophic events such as heart attacks and strokes. Without the growth of specialized expertise, these advancements would not exist, and care would still be constrained by outdated, less effective methods.

System and Societal Impact

The absence of medical specialization would also place immense strain on health systems. Individuals would require longer hospital stays and more resource-intensive interventions, driving up costs and delaying access for others. Economically, the burden of disease would weigh heavily on families, workplaces, and governments, while socially, the lack of progress in mental health, pediatrics, or geriatrics would leave vulnerable populations underserved. Medical specialization has therefore been central not only to saving lives but also to strengthening health systems and improving social well-being.

The Role of Nursing Specialization

Equally transformative has been the growth of nursing specialization over the past forty years, particularly the role of Clinical Nurse Specialists (CNSs). These highly educated nurses bridge the gap between evidence and practice, bringing advanced clinical expertise, leadership, and research translation into every corner of the health system. Without their evolution, nursing would have remained largely confined to generalist roles, with limited authority to assess, prescribe, or lead in complex environments. Individuals with multifaceted conditions would be left without the benefit of CNS expertise, relying solely on physicians in an already overstretched system.

Clinical Consequences of Nursing Specialization

The impact of CNSs is visible in countless clinical situations and across nearly every domain of care. In oncology, for example, a CNS might guide a person through the overwhelming start of chemotherapy, explaining each step, suggest adjusting medications to manage side effects, and provide essential psychosocial support throughout treatment to individuals and the family. In critical care, a CNS may notice a subtle change in a person's blood pressure or respiratory rate, signs that could easily be missed, and they can identify subtle changes in a person's status, intervene early, and prevent

deterioration before it becomes life-threatening. In community health, CNSs often design chronic disease management programs that help individuals with conditions such as diabetes or heart failure stay out of hospital and live healthier lives at home. Without these interventions and their expertise, many individuals would face avoidable suffering, complications, and premature decline, and consequently, outcomes would be poorer, complications more common, and health systems more burdened.

The Impact of Nursing Research

Nursing research has amplified these contributions by producing evidence that shapes clinical practice and policy. For example, nurse-led wound care research has led to better protocols that prevent infection and shorten healing time and recovery, sparing individuals from prolonged pain and hospitalization. Falls prevention studies have introduced strategies, like environmental modifications and tailored exercise programs, that protect older adults in hospitals and long-term care homes from devastating injuries. Transitional care research has shown that when CNSs call individuals after discharge, review medications, and arrange follow-up appointments, these interventions prevent complications, reduces significantly unnecessary readmissions. Each of these findings reflects not only improved system outcomes but also deeply human benefits: the older adult who avoids a fracture and keeps their independence, or the cardiac person who recovers at home rather than being readmitted in crisis. Crucially, nursing research emphasizes person-centered approaches, ensuring that care is not only technically sound but also compassionate, accessible, and equitable. Without these contributions, modern health care would be less safe, less effective, and less humane.

Societal Impact of CNS Practice

The broader societal benefits of CNS practice are equally clear. Vulnerable groups, including older adults, children with complex conditions, and individuals with mental health needs, now benefit from specialized nursing interventions. In rural and remote communities, often underserved, where specialist physicians may be hours away, CNSs often provide advanced care that makes the difference between stabilization and tragedy. In mental health, CNSs bring both expertise and empathy to individuals who might otherwise fall through the cracks of the system. Families caring for children with complex needs often credit CNSs with coordinating services, reducing hospital visits, and helping them navigate systems that would otherwise feel impossible to manage. Beyond statistics, these stories show how CNSs protect not just health outcomes, but quality of life and dignity for individuals and families. Economically, CNSs reduce hospital stays, prevent complications, and improve continuity of care, directly strengthening the sustainability of the health system.

Policy Implications

From a policy standpoint, both medical and nursing specialization have been central to advancing health care quality, equity, and sustainability. The past twenty years of medical specialization have enabled life-saving treatments and precision care, while the last forty years of CNS practice have improved system efficiency, reduced inequities, and humanized person care. To imagine a society without these innovations is to imagine higher mortality, greater suffering, and health systems under collapse from avoidable burdens.

In brief

At its heart, this story is not only about health systems and policy, but about the difference specialists, especially Clinical Nurse Specialists, make in the lives of individuals and families. CNSs

are often the ones who notice the quiet change in a person's condition before it becomes critical, who redesign care pathways to prevent suffering, and who stand with families as they navigate fear and uncertainty. Their work is measured not just in fewer complications or shorter hospital stays, but in trust built, dignity preserved, and hope restored.

The same is true for medical specialists whose knowledge and precision have transformed survival rates and offered people new chances at life. Together, medical and nursing specialization form the twin pillars of modern health care, driving both scientific advancement and compassionate practice. To imagine a world without them is to imagine one with shorter lives, greater suffering, and deeper inequities. The lesson for policymakers and leaders is clear: investment in specialization, both in medicine and in Clinical Nurse Specialists, is not a luxury, but an essential commitment to better outcomes, stronger systems, and a more humane future for all.

Specialization in medicine and nursing has saved lives, improved outcomes, and made care more humane. Clinical Nurse Specialists, in particular, have proven indispensable in bridging science and practice, preventing complications, and supporting individuals and families through the most vulnerable moments of illness. Their presence ensures that care is not only effective, but compassionate, coordinated, and accessible.

In conclusion

The contributions of CNSs over the past forty years can be measured in fewer complications, shorter hospital stays, and improved survival, but also in trust built, dignity preserved, and hope restored. These are not small achievements; they are the daily realities that ripple through families and communities. To imagine health care without CNSs is to imagine a system that turns away from its full potential to heal. For policymakers, leaders, and the public, the path forward is clear: Clinical Nurse Specialists are not simply an enhancement to care, they are essential to it. Continuing to support, invest in, and expand CNS roles is both a professional and a profoundly human commitment, to safer care, better outcomes, and a health system that truly serves the people it was built for. To imagine health care without the progress of the last 20–40 years is to imagine shorter lives, greater suffering, and deeper inequities. The path forward is clear: sustained investment in medical specialists, CNSs, and nursing research is not optional, it is a commitment to safer care, stronger systems, and a more equitable future for all.

Sincerely,

Paul-André Gauthier
Clinical Nurse Specialist

For example:

Key Appeals and Recommendations

1. Recognize Specialization as Foundational, Not Optional

- Nursing specializations are not enhancements to the health system, but essential pillars of modern health care. Without them, person outcomes would regress, health inequities would widen, and system sustainability would collapse under avoidable burdens and outcomes.
- Policymakers must view specialization as a core investment, not a discretionary one.

- **Recommendation:** Policymakers must enshrine specialization as a strategic health priority, embedding it into workforce planning, funding models, and system reform initiatives to ensure stability and progress across all sectors of care.

2. Strengthen and Expand Clinical Nurse Specialist Roles

- Clinical Nurse Specialists provide direct, measurable value: reducing complications, shortening hospital stays, preventing readmissions, and improving person experiences.
- CNSs also ensure that evidence translates into practice quickly and effectively, closing the gap between research and bedside care.
- Recommendation: **Expand the integration of CNSs across all care settings**, particularly in underserved areas such as rural and remote communities, pediatric, mental health, geriatrics, and chronic disease management.

3. Invest in Nursing Research as a Driver of Innovation

- Nurse-led research has produced breakthroughs in wound care, falls prevention, transitional care, and person safety, leading to both system efficiencies and better quality of life for individuals.
- Without continued investment, the pipeline of evidence-based interventions that improve care and reduce costs will stagnate.
- Ensure findings translate rapidly into practice to improve care outcomes.
- Recommendation: **Increase dedicated funding for nursing research**, with priority given to research that addresses person-centered outcomes, equity, and health system sustainability.

4. Promote Interdisciplinary Specialization as a System Strength

- Nursing and medical specialization are complementary, not competing. Together, they represent the scientific precision of medicine and the holistic, person-centered focus of nursing. Focusing on team-based model of care will avoid fragmentation of care services.
- Recommendation: **Support policies and models of care that strengthen interdisciplinary collaboration**, ensuring specialists work as integrated teams rather than in silos.

5. Address Health Inequities Through Specialized Roles

- Vulnerable populations, older adults, children with complex conditions, individuals with mental health needs, and rural residents, benefit disproportionately from specialized nursing and medical expertise.
- Recommendation: **Prioritize deployment also of CNSs in underserved communities**, ensuring equitable access to high-quality care.

6. Frame Specialization as an Economic Imperative

- Specialization reduces avoidable hospitalizations, prevents complications, and improves long-term outcomes, thereby reducing strain on the health system and lowering costs for governments and families.
- Recommendation: **Integrate cost-effectiveness evidence into funding models** to demonstrate how investment in CNSs and specialized care produces measurable returns, and into workforce planning.

7. Keep the Human Dimension at the Center

- Beyond statistics, specialization translates into lived experiences: the person with cancer who survives because of targeted therapies, the older adult who avoids a fall because of a CNS-led program, or the family who feels supported rather than abandoned during a health crisis.
- Recommendation: **Embed recipients of care and family voices in policy development**, ensuring reforms are guided not only by efficiency but also by compassion and dignity.

Disclaimer: This article was created with the assistance of ChatGPT, using specific information and guidelines. The author contributed additional content to ensure its relevance to the members, with efforts made to ensure accuracy and coherence.

Clinical Nurse Specialists, Helping Others Along the Novice to Expert Continuum

As a nurse psychotherapist and as a trainer of psychotherapists who are often newly learning, I am continuously reflecting on the best ways to integrate interventions, both clinically and educationally. Editing and writing many chapters for The nurses' guide to psychotherapy: A reference book for nurses providing psychotherapy gave me an opportunity to reflect on how I, as a nurse psychotherapist, integrate multiple forms of psychotherapy. In the book, we identified the Y model developed by Goldberg and Plakun (2013), which has been used for many years to train psychiatry residents in different modalities of therapy. The Y model explains the base of the Y as the foundations of psychotherapy, and I reflected upon how disciplines learn these foundations, inclusive of how to develop therapeutic relationships, in undergraduate curricula, before they begin to understand differing theories and the interventions of specific therapy types.

In the Nurses' guide to psychotherapy, we adapted the Y model to show the arms of the Y as structured and unstructured psychotherapies instead of the previous labels of a CBT arm and a psychodynamic arm. This adaptation was made so that the model could include multiple forms of therapy instead of the two listed as an attempt to be more inclusive of other forms of psychotherapy while maintaining the simplicity of the arms of the Y for learners of various psychotherapy types.

Since the book was published, I have written an article, the Expanded Y model, which branches the arms of the Y together in a diamond at the top to show the opportunity that exists for clinicians to transition from novice to expert (Benner, 1982) when learning many different types of psychotherapies. When psychotherapists begin learning the therapies that stand out to the individual therapist, they then start to move along the novice to expert continuum, at which point they can start to blend and integrate the use of therapies should the therapy type allow for it and as is of benefit to the client. As a trainer in multiple forms of psychotherapy, helping those learning to achieve this blending and movement from novice to expert in different therapies and in different blends of therapies, I considered and further reflected on my role as a Clinical Nurses Specialist. The role of the CNS, the advanced practice nurse, the experienced clinician, is to not only commit to continuous learning, but to explore and to advance the nursing profession and the clinical skills of others.

Sincerely,

Stacey Roles, RN, MScN, PhD,
CCS Psychotherapist
Director of Policy, Practice, and Political Action

*Adapted from blog post on website References

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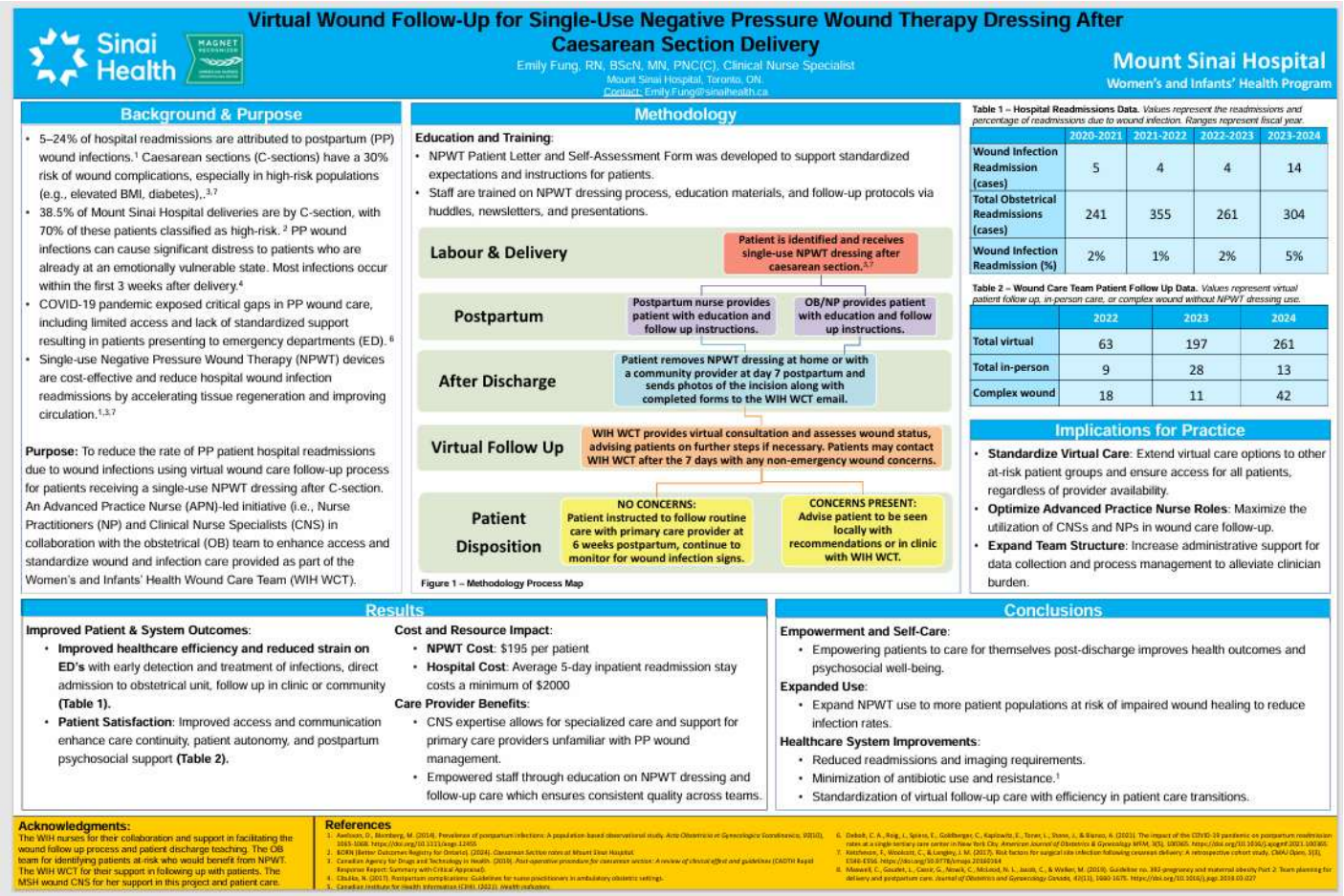

Virtual Wound Follow-Up for Single-Use Negative Pressure Wound Therapy Dressing After Caesarean Section Delivery

Sinai Health

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Mount Sinai Hospital
Women's and Infants' Health Program

Background & Purpose

- 5–24% of hospital readmissions are attributed to postpartum (PP) wound infections.[1] Caesarean sections (C-sections) have a 30% risk of wound complications, especially in high-risk populations (e.g., elevated BMI, diabetes),.[3,7]
- 38.5% of Mount Sinai Hospital deliveries are by C-section, with 70% of these patients classified as high-risk. [2] PP wound infections can cause significant distress to patients who are already at an emotionally vulnerable state. Most infections occur within the first 3 weeks after delivery.[4]
- COVID-19 pandemic exposed critical gaps in PP wound care, including limited access and lack of standardized support resulting in patients presenting to emergency departments (ED). [6]
- Single-use Negative Pressure Wound Therapy (NPWT) devices are cost-effective and reduce hospital wound infection readmissions by accelerating tissue regeneration and improving circulation.[1,3,7]

Purpose: To reduce the rate of PP patient hospital readmissions due to wound infections using virtual wound care follow-up process for patients receiving a single-use NPWT dressing after C-section. An Advanced Practice Nurse (APN)-led initiative (i.e., Nurse Practitioners (NP) and Clinical Nurse Specialists (CNS) in collaboration with the obstetrical (OB) team to enhance access and standardize wound and infection care provided as part of the Women's and Infants' Health Wound Care Team (WIH WCT).

Methodology

Education and Training:

- NPWT Patient Letter and Self-Assessment Form was developed to support standardized expectations and instructions for patients.
- Staff are trained on NPWT dressing process, education materials, and follow-up protocols via huddles, newsletters, and presentations.

Figure 1 – Methodology Process Map

Table 1 – Hospital Readmissions Data. *Values represent the readmissions and percentage of readmissions due to wound infection. Ranges represent fiscal year.*

	2020-2021	2021-2022	2022-2023	2023-2024
Wound Infection Readmission (cases)	5	4	4	14
Total Obstetrical Readmissions (cases)	241	355	261	304
Wound Infection Readmission (%)	2%	1%	2%	5%

Table 2 – Wound Care Team Patient Follow Up Data. *Values represent virtual patient follow up, in-person care, or complex wound without NPWT dressing use.*

	2022	2023	2024
Total virtual	63	197	261
Total in-person	9	28	13
Complex wound	18	11	42

Implications for Practice

- **Standardize Virtual Care**: Extend virtual care options to other at-risk patient groups and ensure access for all patients, regardless of provider availability.
- **Optimize Advanced Practice Nurse Roles**: Maximize the utilization of CNSs and NPs in wound care follow-up.
- **Expand Team Structure**: Increase administrative support for data collection and process management to alleviate clinician burden.

Results

Improved Patient & System Outcomes:

- **Improved healthcare efficiency and reduced strain on ED's** with early detection and treatment of infections, direct admission to obstetrical unit, follow up in clinic or community **(Table 1).**
- **Patient Satisfaction**: Improved access and communication enhance care continuity, patient autonomy, and postpartum psychosocial support **(Table 2).**

Cost and Resource Impact:

- **NPWT Cost**: $195 per patient
- **Hospital Cost**: Average 5-day inpatient readmission stay costs a minimum of $2000

Care Provider Benefits:

- CNS expertise allows for specialized care and support for primary care providers unfamiliar with PP wound management.
- Empowered staff through education on NPWT dressing and follow-up care which ensures consistent quality across teams.

Conclusions

Empowerment and Self-Care:

- Empowering patients to care for themselves post-discharge improves health outcomes and psychosocial well-being.

Expanded Use:

- Expand NPWT use to more patient populations at risk of impaired wound healing to reduce infection rates.

Healthcare System Improvements:

- Reduced readmissions and imaging requirements.
- Minimization of antibiotic use and resistance.[1]
- Standardization of virtual follow-up care with efficiency in patient care transitions.

Acknowledgments:
The WIH nurses for their collaboration and support in facilitating the wound follow up process and patient discharge teaching. The OB team for identifying patients at-risk who would benefit from NPWT. The WIH WCT for their support in following up with patients. The MSH wound CNS for her support in this project and patient care.

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Director of Membership & Services.

CNS-ON Education Award 2025-2026

Check our website: http://cns-ontario.rnao.ca/awards

Webinar " Colleague to Colleague "

a Webinar on ZOOM

Wednesday, Dec. 10, 2025 at **20:00** hr. ET

Guest Speaker:

Rick Bassett,

MSN, RN, APRN, ACNS-BC, CCRN, FCNS, LSSGB

President of NACNS

National Association of Clinical Nurse Specialists

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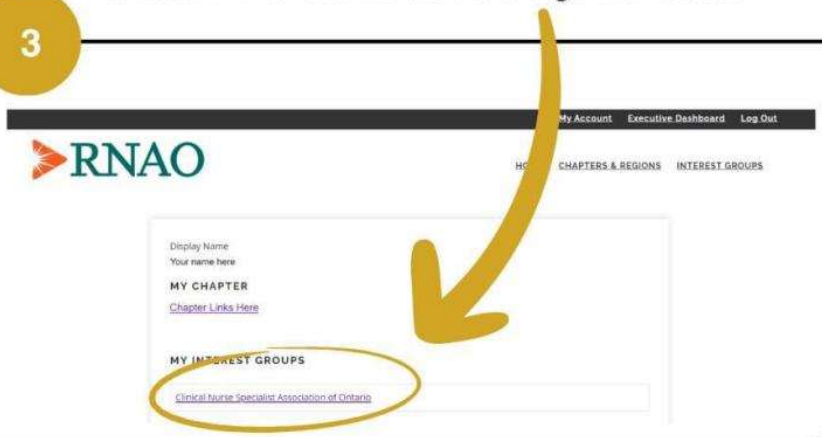

CNS Association of Ontario 2025-2026 Executive members

President (ENO) (2023-2027)	Paul-André Gauthier
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Director of Membership & Services (ENO) (2022-2026)	Emily Fung
Director of Research & Education (ENO) (2025-2027)	Mary-Lou Martin
Social media (ENO) (2025-2027)	Paul-André Gauthier
Workplace Liaison (ENO) (2023-2027)	Robin Coatsworth Puspoky
Member at Large (2025-2027)	Elsabeth Jensen
Graduate Nursing Student Representative (ENO) (2025-2027)	Krissy Jordan

Email: cnsOntario1@gmail.com

https://chapters-igs.rnao.ca/interestgroup/6/about

https://www.facebook.com/pages/Clinical-Nurse-Specialists-Association-of-Ontario-Canada/113210988761198?ref=ts&fref=ts

https://instagram.com/cns_ontario?igshid=YmMyMTA2M2Y=

https://twitter.com/cns_ontario/status/1519437359045124096?s=21&t=oWhFFkS0NkwwYp4zlgvh2g

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

CNS Association of Ontario Education Award 2025-2026

Five (5) bursaries in the amount of **$ 2,000 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 (and member also the previous membership year);
- Who currently resides in Ontario;
- Who has submitted their curriculum vitae / résumé (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 as a CNS.

Deadline: Friday, January 9th, 2026 before 1500 hours (3:00pm)

Submit to:

Clinical Nurse Specialist Association of Ontario

Subject: CNS-ON educational award.

CNSOntario1@gmail.com

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.*

- The bursary will be **awarded** by the CNS Association of Ontario's Executive — **before the end January 2026.**
- 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, 2026, preferably before that date once it is completed.**

International Council of Nurses (ICN)

In June 2025, I recently attended the International Council of Nurses (ICN), a federation of more than 130 national associations representing the over 29 million nurses worldwide. ICN hosted in partnership with the Finnish Nurses Association, the ICN Congress "*Nursing Power to Change the World*" at the Messukeskus Helsinki Convention Centre, Helsinki, Finland. It brought together nursing professionals from around the world to share knowledge, collaborate and advance the field of nursing. It was a great success, over 7,000 nurses from around the world to celebrate the power of nursing and advance major global health goals. The week's programme showed that when nurses are properly supported and empowered, they can truly transform our health systems and our world.

There was an incredible lineup of international speakers, including Amelia Tuipulotu, Byron Scott, Carolyn Jones, Helen Clark, James Buchan, and many others whose insights inspired and energized participants.

Over 10,000 abstracts were evaluated. Key topics included: nursing leadership; people-centred care; advanced practice nursing; value-based care; education; building a sustainable health workforce; delivering essential care in crisis and conflict; revolutionizing health care with connectivity, analytics and automation; future health challenges; professional standards for quality nursing care; and nursing research and innovation. There were Main sessions, Plenary sessions, 69 Concurrent sessions, 39 Symposiums, and over 1,000 e-posters.

Presentations about the work of **Clinical Nurse Specialists** included:

- Confirming the Clinical Nurse Specialist Role in Discharge Planning: The Experience of DPNs in the Medical Center *by* Hui-Ya Chan, Jui-Yi Chen, Ying-Siou Lin, Guan-Liang Chen, Ying-Ru Li, Yi-Ling Lin, Yu-Ying Chen (Taiwan);
- The Barrel of Wishes – The Multiple Roles of the Clinical Nurse Specialist *by* Piritta Masseli (Finland);
- Policy to Support Role Clarity and Organizational Integration of the Role of the Clinical Nurse Specialists in British Columbia: A Multi-Method Study of Workforce Transformation *by* Leah Lambert, Sandra Lank Jaglsir Kaur, Natasha Prodan-Bhalla, Kevin Hare, Sally Thorne (Canada);
- From Practice to Knowledge: The Education Insights of Respiratory Clinical Nurse Specialists & Advance Nure Practitioners: A Qualitative Exploration Study, *by* Bridget Murray (USA);
- Strengthening Health Care System: The Evolution of Clinical Nurse Specialists in South Africa, *by* Portia Jordan, & Sindizama Mthembu (South Africa);
- Elevating the Value & Connection of the Clinical Nurse Specialist within the Context of Mental Health & Addiction Health Care Programs *by* Mary-Lou Martin, Carrie Bullard, Kelly Holt, Brendan Carmichael, Y. Medulla, Matthew Payette, Kelly Shaw (Canada);
- Finding the Clinical Nurse Specialist (CNS) in Multiprofessional Advanced Practice – A Practice Quality and Safety Issue, *by* Bongi Sibanda (USA).

The International Council of Nurses, Nurse Practitioners/Advance Practice Nurses (ICN NP/APN) Network Meeting was held. The group has had 14 biennial conferences since its inception and seeks to engage a global audience. It has 4,000 members. The subgroups included Research, Practice, Health Policy, Education and Students. An update on each subgroup was provided and a presentation on nurse anesthetists followed.

A commercial and professional exhibition included hosting a dynamic series of sessions including policy cafes, Impact Hub Presentation, ICN booth, Tech Hub, and professional associations, and businesses.

ICN President, Dr. Pamela Cipriano, and ICN CEO, Howard Catton, welcomed the new board and the 30th President of ICN, Jose Luis Cobos Serrano, who chose the watchword "Empowerment".

The congress and the work presented showcased the work of many different types of nurses in many different settings across the world. It was both exciting and inspiring.

The next **31st ICN Congress** will be in **Taipei, in June 8-11, 2027**.

Sincerely,

Mary-Lou Martin, RN, MScN, MEd
Director of Research & Education

International Council of Nurses, Nurse Practitioners/Advance Practice Nurses (ICN NP/APN) Network Conference

- **14th ICN NP/APN** Network Conference **2026**, International Council of Nursing's NP/APN Network in Nashville, Tennessee, USA, September 14-17, 2026. The call for abstracts began June 16, 2025.
  - Accepting poster & podium presentations that showcase innovation, evidence-based practice, policy advancements & leadership strategies that contribute to the growth & impact of advanced practice nursing;
  - Transforming Practice Models: Innovative Approaches to Care Delivery;
  - Strengthening Education: Advancing Curriculum & Training Structures;
  - Advocacy in Action: Amplifying the Voice of NP/APNs for Equitable Healthcare;
  - Regulatory Frameworks for Practice: Navigating the Evolving Landscape;
  - Evidence-Based Impact: Research Shaping Patient Outcomes & Practice;
  - NP/APN Leadership in Healthcare: Driving Change & Inspiring the Profession;
  - Engaging the Next Generation: Fostering Student Involvement in Global Practice;
  - Leveraging Digital Health: Building Literacy & Competency for Practice in the Digital Era.

Open to advanced practice nurses, researchers, educators, students, & health care professionals involved in advanced practice nursing. Interdisciplinary submissions are welcomed.

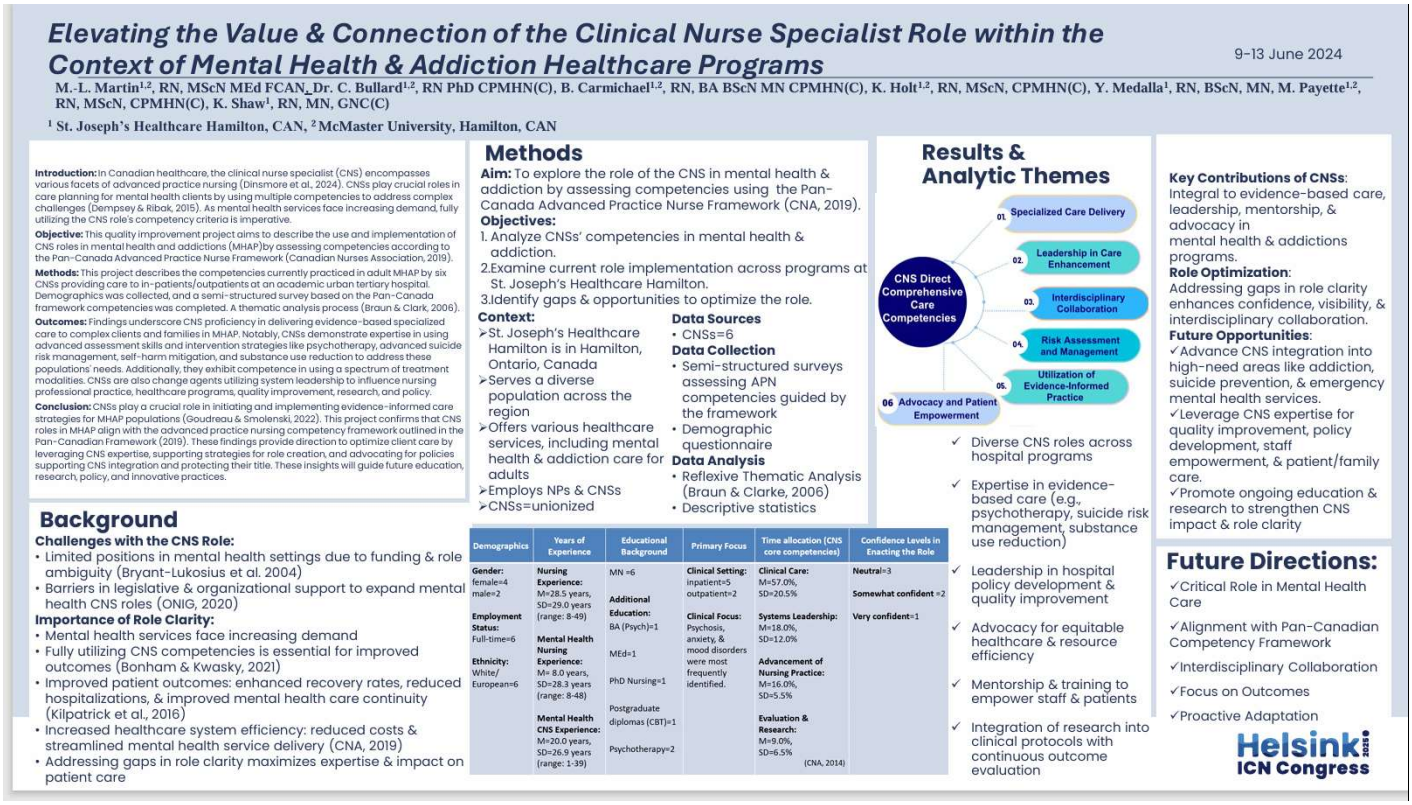
- "Advanced Practice Nurses: United for Global Impact, Innovation and Care"

You are invited to share your expertise with advanced practice nursing leaders, educators, researchers and practitioners at the 2026 conference! www.icn.ch/events/icn-npapn-network-conference-2026 the Submission Deadline was October 1st, 2025

2025 ICN publications www.icn.ch/resources/publications-and-reports

The ICN has 3 recent publications:

- Renewing the Definition of Nursing and a Nurse, June 2025.
- INTERNATIONAL NURSES DAY 2025 Caring for Nurses Strengthens Economies.
- Involving Nurse Leaders in Strategic Health Workforce Planning an ICN Policy Guide – 2025



Biographie

Mary-Lou Martin is a clinical nurse specialist in independent practice. She received a MScN and a MEd from the University of Toronto. Her clinical experience is in the recovery of clients with mental health issues &/or forensic issues. Her educator experience is in the education and mentoring of staff, and the tutoring/teaching of university nursing students. She is the co-author of the *Short-Term Assessment of Risk and Treatability*, a guide for the dynamic assessment of strengths and vulnerabilities across 7 risk domains (violence to others, suicide, self-harm, self-neglect, unauthorized absence, substance use and victimization).

Her current research and evaluation projects include self-management and the role of clinical nurse specialists in mental health. She has published articles in peer-reviewed journals and chapters in books. She is a reviewer for several nursing journals. She has been on the development panels for two published *Best Practice Guidelines, Establishing Therapeutic Relationships and Alternatives to Restraint*. She is a Fellow of the Canadian Academy of Nursing (FCAN). Mary-Lou is a past president of the Clinical Nurse Specialist Association of Ontario (CNS-ON) and former president of the Clinical Nurse Specialist Association of Canada (CNS-C).