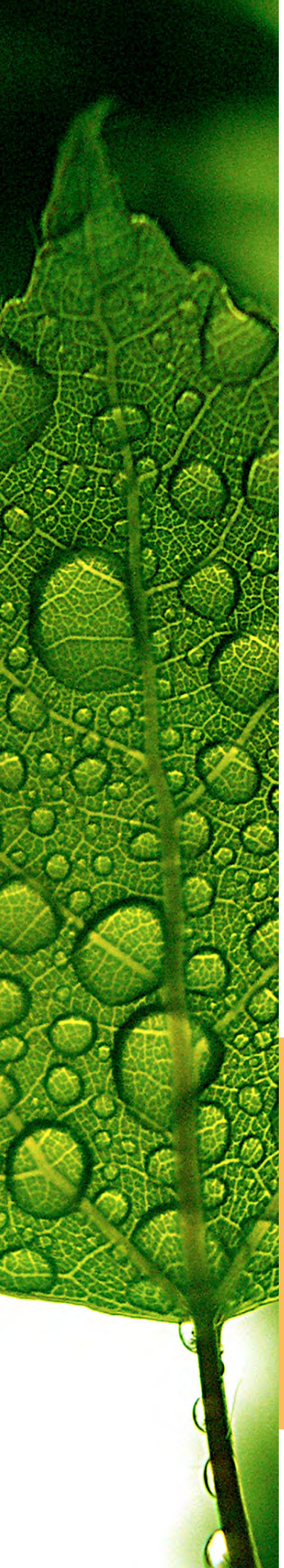
University of Victoria
Nursing

COMMUNIQUÉ

UVic School of Nursing - Research and Scholarship Publication SPRING 2016

Thematic issue on Knowledge Synthesis



WELCOME LETTER

"When you know better, you do better" —Maya Angelou

Welcome to the Spring issue of the University of Victoria School of Nursing Communique that is focused on Knowledge Synthesis. Why knowledge synthesis? Knowledge development is iterative, with knowledge developing over time, one study building on, or evolving from previous research. Nurses use knowledge to continually grow practice. Yet, with the proliferation of research, how does a nurse select from what is often a vast number of studies and make sense of the studies to inform practice? Knowledge synthesis (KS) offers a solution. KS is a systematic research process that enables one to integrate the findings from a number of individual studies, thus providing the user with confidence that the results will enrich practice, or inform the development of cogent policies.

Like photosynthesis, knowledge synthesis takes 'raw materials', individual studies, and through an enlightened, systematic process catalyzes new knowledge. The UVic SON has supported the development of the capacity of faculty and students to carry out Knowledge Synthesis initiatives since 3 faculty members and one UVic librarian attended Joanna Briggs Institute (JBI) training for systematic reviews in 2012 at Queen's University. Since then additional faculty, PhD students, and one librarian have attended week-long JBI training sessions. Thus our capacity for engaging in knowledge synthesis work at the UVic SON is developing. At the March 18, 2016 conference, as a JBI team, we will reach out to our practice partners to begin a process of building bridges between academia and practice by identifying focused areas for future KS initiatives. Together, we hope we can strengthen nursing to benefit those in nurses' care.

In this issue of the Communique, University of Victoria School of Nursing faculty and students present their knowledge synthesis work, some reviews are a result of the UVic SON JBI initiative, and some were carried out using other processes such as [Nice, Cochrane].

SIncerely,

Lynne Young, PhD
Professor and co-director, UVic School of Nursing JBI Inititiave

"However high we climb in the pursuit of knowledge we shall still see heights above us, and the more we extend our view, the more conscious we shall be of the immensity which lies beyond."

Sir William George Armstrong Address to the British Association (1863), in Report of the Thirty-Third Meeting of the British Association for the Advancement of Science (1864)

CLEARING THE AIR

A PROTOCOL FOR A SYSTEMATIC META-NARRATIVE REVIEW ON THE HARMS AND BENEFITS OF E-CIGARETTES and VAPOUR DEVICES

Marjorie MacDonald, Renee O'Leary, Tim Stockwell, Dan Reist

Background
Under the shadow of the tobacco epidemic, the sale and use of e-cigarettes and other vapour devices is increasing dramatically. A contentious debate has risen within public health over the harms and benefits of these devices. We seek to clarify the issues with a systematic review that informs the pressing regulatory and public health decisions to be made regarding these new products.

Methods/Design
Using an integrated knowledge translation approach, public health researchers and knowledge users will work collaboratively throughout the project. Our research questions are: (1) What are the health risks and benefits of vapour devices, and how do these compare to cigarettes? (2) What is the harm reduction potential of vapour devices for individuals, the environment, and society? (3) Does youth vapour device experimentation lead to cigarette use? (4) Can vapour devices be effective aids for tobacco cessation? and (5) What is the potential toxicity of second-hand vapour?

We are using meta-narrative review (MNR) because of its capacity to address contestations around a topic. MNR is a relatively recent constructivist synthesis methodology developed to summarize, synthesize and interpret a diverse body of literature from multiple traditions that use different methods, theoretical perspectives, and data types. It is systematic in that it is conducted using an established rigorous and transparent method. This methodology involves the judicious combination of qualitative and quantitative research evidence, the theoretical literature, and other relevant sources of data (e.g., editorials, and news items in academic journals). The contentious debate around vapour devices makes MNR a good fit for this study because the methodology is particularly suited to topics where there is dissent about the nature of what is being studied, and the best empirical approach to studying it.

The project has six phases. We have completed the first two and the third is in progress. In the planning phase, we finalized the research questions. In the search phase, we located academic publications and grey literature aided by a research librarian. The mapping phase involves categorizing these papers into research traditions to understand different perspectives on the evidence for each research question. In the appraisal phase, we will select and evaluate the relevant papers. Finally, in the synthesis phase, using analytic techniques unique to meta-narrative methodology (e.g., paradigm bridging, paradigm bracketing, interplay, and meta-theorizing), we will compare and contrast the evidence from different research traditions to answer our research questions, identifying over arching meta-narratives. In the final stage, the full team will draft recommendations and knowledge translation products to be disseminated through a variety of strategies identified and preferred by our decision making partners.

Conclusion
Meta-narrative synthesis has the unique capacity to expose the debates that are influencing the interpretation of empirical studies on vapour devices. We seek to "clear the air" with an even-handed review of the evidence and an understanding of the tensions within public health so that we can offer clear-headed recommendations for policy, regulation, and future research.

Study funded by a CIHR Knowledge Synthesis grant from the Knowledge Translation Unit to M. MacDonald and T. Stockwell (principal Investigators). We acknowledge the significant contributions of our Research Coordinator Renee O'Leary, and our knowledge user partners: Perry Kendall, Provincial Health Offices, BC Ministry of Health; Matt Herman, BC Ministry of Health; Frank Welsh, Director of Policy Canadian Public Health Association.

CONCEPTUAL FOUNDATIONS OF A PALLIATIVE APPROACH

A KNOWLEDGE SYNTHESIS

Cara Pearson, Pat Porterfield, Rick Sawatzky and Kelli Stajduhar

Beginning in 2011, a team of British Columbia nursing researchers, practitioners and administrators, known as Initiative for a Palliative Approach in Nursing: Evidence and Leadership (iPANEL, ipanel.ca), came together. Much of what is known about caring for people who are approaching end of life comes from our experiences of caring for cancer patients. We recognized that people who were dying from chronic, life-limiting illnesses, such as dementia, frailty, COPD and kidney disease, do not receive adequate palliative care services. We also recognized that most people with these long-term advancing illnesses could be better served by a different type of care. A palliative approach to care has become increasingly taken up in other parts of the world. iPANEL was formed with the goal of furthering the integration of a palliative approach throughout the BC health care system in order to improve care for those with chronic life-limiting illness and their family members.

One of the first of many projects undertaken by members of the iPANEL team was a knowledge synthesis on how a palliative approach is delineated in the literature. This knowledge synthesis has now been published and is available open access: Conceptual foundations of a palliative approach: A knowledge synthesis (http://www.biomedcentral.com/1472-684X/15/5). The goal of this research was to clarify the meaning of a "palliative approach" to care for people who have chronic life-limiting conditions. We began with the knowledge that in order to care for this particular patient population, this required a blending of palliative care and chronic disease management principles and practices. A comprehensive search of 11 research databases for the intersection of these terms (see diagram) generated 190,204 search results. In order to sift through this many documents, a probabilistic, iterative computer-assisted screening program was developed and utilized alongside manual screening (see the full article for more detail), resulting in a final set of 91 research articles included for analysis. Narrative synthesis and thematic analysis methods were applied to conceptualize key characteristics of a palliative approach.

This research shows that there is a distinction between a palliative approach and the way palliative care has been enacted as a specialized service. Three key features of a palliative approach include: (1) upstream orientation towards the needs of people who have life-limiting conditions and their families, (2) adaptation of palliative care knowledge and expertise, and (3) operationalization of a palliative approach through integration into systems and models of care that do not specialize in palliative care.

(1) Upstream orientation to care
A palliative approach to care begins by recognizing the life-limiting nature of many chronic conditions. Applying palliative care principles earlier in the course of an illness requires having an understanding of different chronic disease trajectories in order to determine where a person is on that trajectory. With this understanding, the changing needs of patients and families can be better identified and addressed, for example through proactive care planning, informed decision making, and advance care planning.

(2) Adaptation of palliative care knowledge and expertise
A palliative approach goes beyond simply applying knowledge and expertise from palliative care to practice; it requires adaptation to different patient populations and their unique disease profiles, in particular, accommodating the uncertainty inherent in many disease trajectories. Adaptation of symptom management, communication with patients and families, and partnership strategies were evident in the literature.

(3) Integration and contextualization within the health care system
Delivering a palliative approach early in illness trajectories necessitates greater capacity within the health care system to recognize and to address the evolving care needs of people with chronic life-limiting conditions. There is no single model of care delivery that best enables a palliative approach to care. Rather, a

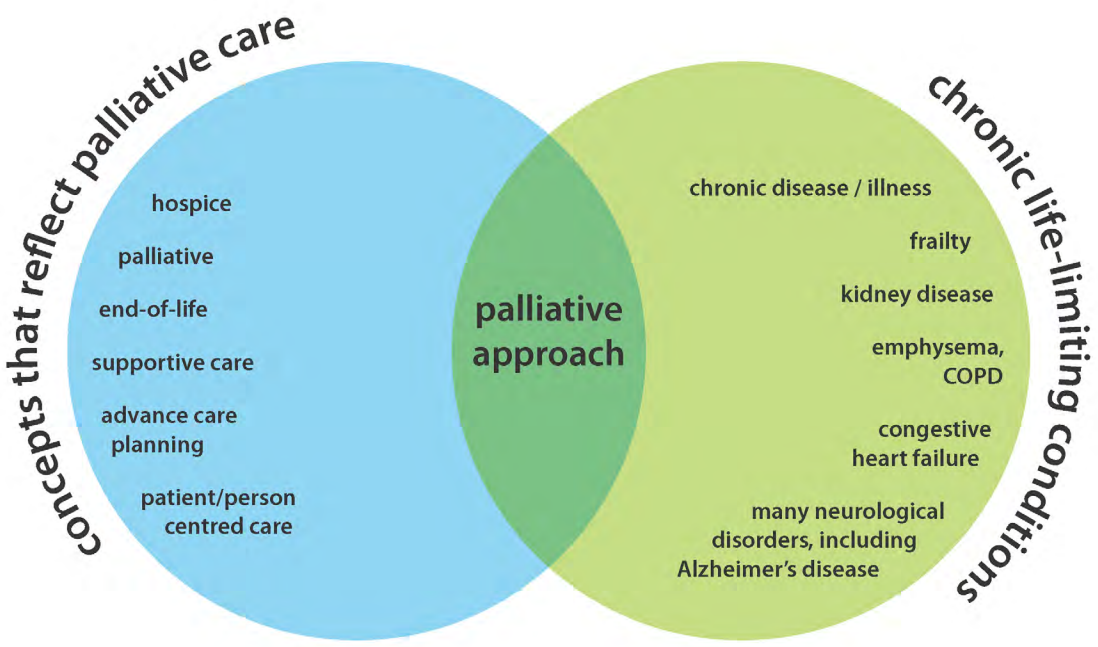
palliative approach integrated and embedded throughout all existing providers and settings of the health care system is most likely to have a meaningful impact. Three prominent models for integration emerged: (1) into generalist practice, (2) into disease-specific approaches, and (3) early in the disease trajectory.

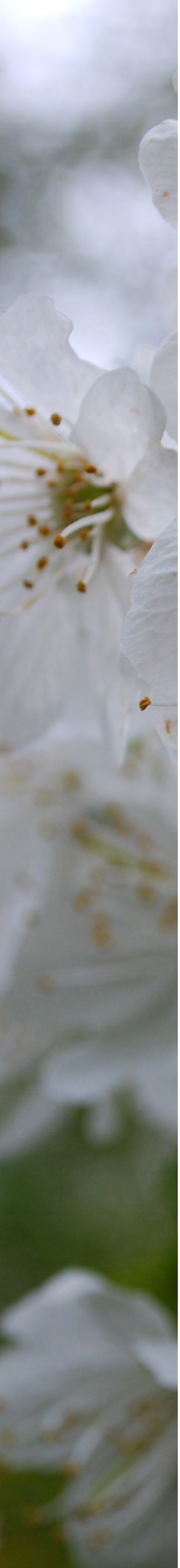
Model 1: Integration of a palliative approach into generalist practice
The key feature of this model is the integration into care sectors rather than into specific disease care plans, enabling flexibility when caring for people with multiple co-morbidities. One example is the Gold Standards Framework (GSF) in the United Kingdom, which focuses on primary and residential care settings, and advocates for a total system transformation to care of the dying. The GSF provides education and capacity-building for all members of the care team. Overall, this model involves palliative care specialists working with generalist care providers to build capacity for delivering a palliative approach.

Model 2: Disease-specific approaches to care delivery
The key feature of this model is that palliative care principles are adapted and integrated into all sectors of the health care system so that people who have particular life-limiting conditions are supported throughout their illness progression. This involves collaboration between palliative care and chronic disease or geriatrics care providers, and coordination across health care sectors to ensure a full breadth of services. One example of this is chronic care teams and community health nurses working collaboratively through information technology to support COPD patients and their families. This necessitates ongoing capacity building for a palliative approach through intentional partnerships.

Model 3: Applying palliative care "early" in the disease trajectory
The key feature of this model is that it closely resembles traditional palliative care but is delivered earlier than it traditionally would be, typically by palliative care specialists. One example is outpatient visits with specialist palliative care providers where patients who had been diagnosed with metastatic non-small-cell lung cancer were able to discuss symptoms, goals of care, decision-making and care coordination. This model relies on increased and routine involvement of palliative care specialists early in and throughout the illness trajectory, and has mostly been applied in populations of cancer patients. Given the focus on cancer, less adaptation of palliative care knowledge is required.

The findings of our knowledge synthesis provide much needed conceptual clarity regarding a palliative approach. Such clarity is of fundamental importance for the development of healthcare systems that facilitate the integration of a palliative approach in the care of people who have chronic life-limiting conditions.





SPOTLIGHT
THE SCHOOL OF NURSING JOANNA BRIGGS INSTITUTE

REGISTERED SYSTEMATIC REVIEW TITLES

The effectiveness of lay worker or volunteer-operated community-based blood pressure clinics as measured by average changes in blood pressure in clinic users over time: a systematic review protocol - *Pal Skar*

Student and educator experiences of maternal child simulation-based learning: a systematic review of qualitative evidence *-Karen MacKinnon*

The phenomenon of pre briefing in simulation based learning for health professionals : a systematic review of qualitative evidence - *Maureen Ryan*

The effectiveness of 'offsite' simulation learning events compared to 'onsite' simulation learning events on the performance of health professionals: a review of quantitative evidence - *Maureen Ryan*

Nurses' experiences of organizational change: a systematic review protocol - *Darlaine Jantzen*

The experiences of pre-licensure or pre-registration health professional students and their educators for working with intra-professional teams: a systematic review of qualitative evidence - *Diane Butcher*

Prodromal and acute symptoms of an acute myocardial infarction in adult women: a systematic review of quantitative evidence - *Clare Koning*

AM I HAVING A HEART ATTACK?

Clare Koning, Diane Butcher, Lynne Young

Have you ever wondered what it feels like to have a heart attack? Would you feel chest pain, jaw pain, back ache, or no pain at all? This is what this review aims to find out. While ischemic heart disease is classified as the leading cause of death globally, it is often not well characterized in women, and not recognizing the symptoms as a first sign of a heart attack may be the reason why women are dying at an increasing rate.

In an attempt to understand this phenomenon in more detail, a prevalence systematic review is proposed to calculate the prevalence of specific heart attack symptoms in adult women. More specifically, this review will focus on published primary literature that studies women's acute myocardial infarction symptoms as well as vital statistics data, government reports, population surveys, and disease associations data reports. Using data extraction and statistical calculations guided by the Joanna Briggs Institute process and protocols, the relevant data will, where possible, be statistically pooled for meta-analysis, with the goal of calculating a pooled estimate and generating a quantitative summary.
What does this mean for women and health care providers? Well, this prevalence systematic review holds value in gaining a deeper understanding of what specific symptoms are experienced by this population and how these symptoms compare to the clinical diagnostic criteria used globally. In addition, this review could assist in informing health care decision-making, development, and resource distribution, while promoting and enhancing cardiovascular knowledge and education of women's acute myocardial infarction symptoms.

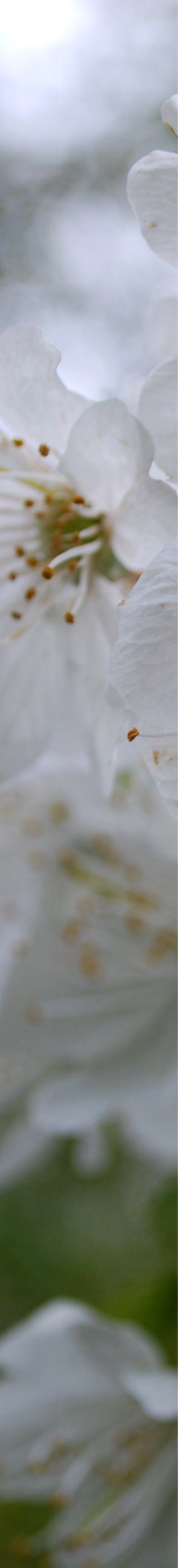
DOES COMMUNITY-BASED PHYSICAL ACTIVITY IMPROVE HEALTH IN OLDER WOMEN?

Young, L.E., Koning, C., Sheets, D., Skar, P., Schick-Makaroff, K.

It may be common knowledge that physical activity has the potential to improve health, but how effective is it in older women. Older women have a unique set of challenges, especially those living independently, and with aging, physical activity can at times be difficult. So far, there has been very little research on the health benefits of physical activity on physical health outcomes for older women living independently in the community.
To expand on this, a group of researchers commenced a systematic review of randomized controlled trial studies of physical activity interventions designed to improve physical health of healthy older women living independently in the community. This study was guided by the Joanna Briggs Institute. What they found was unexpected in some ways.

After an exhaustive search of literature published between 2000-2014, 469 articles were retrieved; only 10 met criteria and appraisal standards to be included for review and synthesis. Various positive health outcomes were reported that could be attributed to the interventions including improved strength, enhanced balance and self-confidence, fewer reported falls, improved bone density and reduced risk of fractures, increased speed of activities, and favourable physiological parameters. While all studies used a randomized controlled trial methodology that tested a physical activity intervention on older women living independently in the community, not all criteria were the same. There was considerable heterogeneity/difference in the types of interventions, the settings, and outcome measures. In addition, there were methodological limitations, for example, low sample sizes and lack of attention to power analyses, reduced the possibility that effect sizes across studies could be pooled.

While this review documented the health benefits of physical activity interventions for older women, the studies as a collection were unfortunately inadequately robust to inform practice or policy. This opened up an opportunity for future studies on the health benefits of physical activity for older women to be designed to include larger sample sizes, report power analyses, and focus the number and type of variables studied. So to answer the question posed above: does community-based physical activity improve health in older women? Yes, absolutely according to the reviewed studies, but much more rigorous research is still needed on this topic.



WHAT IS KNOWN ABOUT STUDENTS AND EDUCATORS LEARNING TO WORK ON INTRA-PROFESSIONAL TEAMS?

Diane Butcher RN MN PhD(c)

Numerous inter-professional initiatives permeate the health care landscape, outlining the need for professionals to collaborate effectively to provide quality patient care. Little attention has been given to intra-professional relationships, where professionals within one disciplinary domain (with more than one point- of- entry to practice) collaborate to provide care. New care models are being introduced in some contexts, where baccalaureate and diploma students of a particular discipline (such as nursing, occupational therapy, dentistry, or physiotherapy) are working closely together in teams to deliver care. Questions thus arise as to how students and educators learn to work on intra-professional teams.

My dissertation work (A Methodologically Plural Exploration of Student, Nurse, and Educator Experiences with Intra-professional Collaboration) includes leading* a Joanna Briggs Institute (JBI) qualitative systematic review, exploring pre-licensure health professional student and educator experiences learning to work on intra-professional teams. Changes in acute care contexts, including the introduction of new care models and team configurations of RNs, LPNs, and Health Care Assistants, have created role ambiguities and overlapping scopes of practice which impact nurses' work and patient care (MacKinnon, Bruce, & Butcher, 2015a; 2015b). How are health professional students prepared for working collaboratively within these teams in shifting care contexts? Currently, there is little research available related to changing healthcare teams and relationships to care outcomes. Further, nurses currently in practice reflect upon how there were few, if any, opportunities as students (baccalaureate and diploma) to work together or learn about each others' roles. Therefore, this systematic review was conducted in order to explore what is currently known (as well as to identify the gaps) about how categories of students under one disciplinary domain learn to engage collaboratively to enhance patient care.

The JBI process of qualitative synthesis - meta-aggregation – includes development of a research question and peer-reviewed protocol (with specific inclusion/exclusion criteria), and comprehensively searching numerous databases for retrieving relevant published and unpublished literature. Our search revealed over 1000 articles to be screened for possible inclusion in this review. After an initial screen, 61 articles remained that required more detailed, second full-text assessment. After this subsequent screening, 12 articles remained to be critically appraised utilizing a standardized appraisal tool. After critical appraisal, seven papers remained that were included in this systematic review.

Sixty-four unequivocal or credible findings, all of which were supported by data (participant quotes) were iteratively synthesized using posters and JBI software in order to create nine categories of findings, grouped by similar meaning. The nine categories were then further iteratively grouped into four synthesized findings: (i) contextual factors (including pedagogical approaches and timing of experiences) may influence experiences of intra-professional learning; (ii) shared learning opportunities contribute to comprehensive care planning and more efficient patient care; (iii) intra-professional learning helps to build collaborative relationships and understanding of roles; and (iv) intra-professional learning is beneficial to students; however, it also creates frustration for students.

Despite its challenges, shared learning experiences assisted students in understanding each other's roles, develop communication and collaborative competencies, develop comprehensive care plans, provide more efficient care, and helped prepare them for their future roles as health care professionals. Various contextual elements could either hinder (hierarchies in practice, academic staff attitudes, inconsistent shared learning activities, lack of understanding or respect of roles, timing of shared experiences) or facilitate (tutor role modelling, clinical/classroom pairings, role playing) shared learning experiences. As only papers from the disciplines of occupational therapy, physiotherapy, and dentistry met the inclusion criteria for this review, further nursing research is needed to understand not only student experiences of intra-professional learning, but also how changes to care teams and models impact experiences of patients and families.

Reviewers: Karen MacKinnon, Anne Bruce, Carol Gordon, and Clare Koning, University of Victoria

MacKinnon, K.A., Bruce, A., & Butcher, D.L. (2015). Re-designing nurses' work: How institutional work practices perpetuate health inequities in small community hospitals. ISIH 6th International Conference: Challenging Health Inequity: A Call to Action, Palma de Mallorca, Spain, June 10-12, 2015.

MacKinnon, K.A., Bruce, A., & Butcher, D.L. (2015). Working to their full scope: Exploring changing work relationships between RNs and LPNs. Invited presentation at Island Health/University of Victoria Health Talks 2015, Victoria, BC, April 20, 2015.

FROM PUPPETS TO AVATARS: A SYSTEMATIC REVIEW OF STUDENT AND EDUCATOR EXPERIENCES OF MATERNAL CHILD SIMULATION-BASED LEARNING

Karen MacKinnon

Simulation usually involves student(s) providing nursing care to a simulated patient who might be a manikin or actor using a standardized scenario. Following the experiential learning opportunity the scenario is debriefed and the clinical situation analyzed with opportunities for reflection on performance. In nursing education, simulation is usually used in a way that complements learning in practice settings. However simulation has also been used: to replace some clinical practice hours, to provide opportunities to practice and assess particular clinical skills, and for remedial learning when students encounter difficulties in practice settings. New forms of simulation are being developed with multiple patients so that nursing students can learn to prioritize care needs and delegate care to other team members.

Currently little is known about how nursing students and/or educators have experienced maternal child simulation or their understandings of the appropriateness and meaningfulness of particular simulation-based learning practices. We conducted a systematic review using the Joanna Briggs methodology. We appraised qualitative studies and peer-reviewed evaluation reports (including mixed methods) that provided qualitative findings when they reported on the relevant learning experiences of students or educators. This review aggregates qualitative research findings from 18 studies (19 papers) that are applicable to the Canadian context for nursing education such as reports from North America, Europe, Australia and New Zealand.

Three synthesized findings were identified: 1) Students experienced simulation as preparation for clinical practice which enhanced their confidence in the practice setting. However, when simulation was being used for evaluation purposes many students experienced anxiety or mixed feelings about the SLE. 2) Teaching and learning practices thought to be appropriate and meaningful included: realistic, relevant and engaging scenarios and tasks (instructional design), a safe non-threatening learning environment, supportive guidance throughout the process of simulation (from pre to post), feedback and debriefing, and integration with the curriculum. 3) Barriers and enablers to incorporating SL into maternal child education were identified including adequate financial and human resources, technological support and faculty development. Simulation was identified as particularly appropriate for maternal child situations that were emergent, infrequent or not available to students in the practice setting. However it was also recognized that some practice experiences could not be simulated.

Reviewers: Karen MacKinnon PhD MScN RN, Lenora Marcellus PhD MN RN, Maureen Ryan PhD MN RN, Diane Butcher MN RN, PhD student (University of Victoria School of Nursing)
Julie Rivers MA Ed BScN RN (Brock Loyalist Collaborative Nursing Program)
Carol Gordon PhD MLS MA (University of Victoria, McPherson Library

GETTING TO IMPLEMENTATION

REALIST SYNTHESIS TO ENHANCE POPULATION HEALTH AND REDUCE HEALTH INEQUITIES

Marjorie MacDonald and Bernie Pauly

There have been many calls over the past 15 years to renew and strengthen public health systems in Canada. In BC, the Framework for Core Functions in Public Health was introduced in 2005 as a public health policy intervention. At the same time, the Core Public Health Functions research Initiative (CPHFRI) was formed to study the implementation and impact of the core functions framework. Today the core functions framework is part of the guiding framework for public health and our research team has grown to include six health authorities in BC, six health units in Ontario, the BC Ministry of Health, the Public Health Agency of Canada, the National Collaborating Centre for the Determinants of Health, the BC Public Health Association, Public Health Ontario, UNBC, McMaster and Western universities. As a result of our initial work on implementation of public and population health interventions, the team identified the need for a better understanding of why some public health interventions are successfully implemented and others are not. While traditional systematic reviews have been conducted on effective implementation in health care there have been few in public health so their relevance to public health is unclear. In most reviews, stringent inclusion criteria have excluded entire bodies of evidence that may be relevant for policy makers, program planners, and practitioners to understand implementation in the unique public health context. In 2014, our team spanning two provinces was successful in receiving CIHR funding to conduct a realist synthesis of the implementation of public health interventions. Realist synthesis is a theory-driven methodology that draws on diverse data from different study designs to explain how and why observed outcomes occur in different contexts and thus may be more appropriate for public health. In other words, what works, for whom, and under what conditions does it work? In undertaking this realist synthesis our first challenge was to find a program theory that would guide our work. While there are implementation frameworks for health care, they are not necessarily reflective of or suited to public health. So, after a review of implementation theories and frameworks, we developed an initial program theory, adapted for public health from the Consolidated Framework for Implementation Research, to explain the implementation outcomes of public health interventions within particular contexts. One of the goals of our work is to refine this initial theory into a 'final' realist program theory that explains important context-mechanism-outcome configurations in the successful implementation of public health interventions. This knowledge is important to evidence based public health. First, developing new public health interventions is costly and policy windows that support their implementation can be short lived. Second, ineffective implementation wastes scarce resources and is neither affordable nor sustainable. Third, public health interventions that are not implemented will not have their intended effects on improving population health and promoting health equity. Understanding the factors that affect whether or not a public health intervention is implemented can contribute to improvements in public health.

We gratefully acknowledge the Canadian Institute of Health Research for funding to support this project and the entire team for their contributions. For a description of the research protocol, see MacDonald, M., Pauly, B., Wong, G., Schick-Makaroff, van Roode, T., Wilson Strosher, H., Kothari, A., Valaitis, R., O, Briain, W. Manson, H., Carroll, S., Tong, S., Lee, V., Dickenson-Smith, K., Ward, M. (in press). Supporting Successful Implementation of Public Health Interventions: Protocol for a Realist Synthesis. Systematic Reviews.

AN ODE TO SYSTEMATIC REVIEWS

Clare Koning

In a world of research so diverse and large,
What evidence do we trust and who is in charge?
Not everything we read qualifies as the best,
How can we base our decisions if we don't put it to the test?
Is one study as good as a synthesis of many,
I'd say no and bet my last penny.
So where do we start, well at the beginning of course,
Let's delve deeper and go to the source.
Do Cochrane, Campbell, and JBI ring a bell?
There are others, but these three do well.
They seek to bring you the best available evidence,
Focusing on rigour, transparency, and relevance.
Their standards are high and the process arduous,
But the rewards and the end results are marvelous.
You're not alone, there are many resources,
Some even provide training and courses.
Guides, tools, and templates help you run the gauntlet,
And as a team you figure it out without too much fret.
There are many different kinds of reviews,
About as many as kinds of shoes!
I'll focus on those that are systematic and peer reviewed,
These were first developed by Cochrane & JBI who in 1990s debuted.
They sought to improve clinical health decision making,
And redefined the evidence hierarchy pyramid and caused a shaking.
Studies that once informed practice and influenced health policy,
Now didn't looks as robust when synthesized - shifting reality.
Systematic reviews collect and sort the best data to answer a question,
Gathering all available evidence, appraising, and extracting – an intense session.
The result is the rigorous synthesis of an immense amount of information,
In the hope that the result is the best possible answer without the frustration.
Why use systematic reviews, well, the time-saving is key,
And the quality of evidence is as squeaky clean as my laundry.
Reviews are useful in policy making, health care, and research,
They yell quality, credibility, and reliability from the top of a perch.
So there it is; a process that's preferred,
Time to get out there and spread the word!

CONFESSIONS OF A CURIOUS RESEARCHER

Renée O'Leary, PhD(c)

I will admit that I am an information sponge. I came to university later in life, at 50 years old, seeking a diploma to obtain the points I needed for immigration. Quite unexpected, I was delighted to find research readily available through hundreds of databases, and I dove right in. The Diploma in the Humanities only whetted my appetite for more information, and I went on gathering research in sociology and tobacco control to fill my undergraduate and MA papers.

A 2009 summer position at the BC Centre of Excellence in Women's Health provided my first experience with a rapid review, on partner support for smoking cessation by pregnant women. I loved every part of the process, and was proud of the report we wrote for the National Institutes for Clinical Excellence (UK). I was delighted to be hired for more systematic reviews, and over the next few years I enjoyed producing literature summaries and systematic reviews on smoking bans, domestic violence interventions, girls' health promotion, and Aboriginal women's tobacco cessation programs.

I was happy in my role as a research assistant, and had no plans for a PhD, until 2011 when I sat in on several post-doctoral lectures at the University of California's Center for Tobacco Control and Education. The lectures were fascinating, but I was put off by how my ideas were dismissed because I was not a PhD. It was in my face: no PhD, no cred, and I decided I needed that credential. Fortunately, my alma matter UVic offered the doctoral program best suited to me: the Social Dimensions of Health, a research based program.

It was during a SDH foundation class with Dr. Worthington that I came to understand that I had a special level of skill and experience with systematic reviews. I had prepped for her class by gathering copies of my reviews; they filled a good-sized binder. As the professor delivered her lecture, I had comments galore, and next thing I knew, she turned the class over to me! Spontaneously, I was able to detail the review steps to my cohort, and easily answered their questions. This experience was an eye opener to me, so I asked other professors and researchers for their thoughts on research synthesis, and was shocked to hear that everyone considered it a chore. I still find that hard to believe – what an exciting task, to learn everything available about a topic and share the information with those who will apply it to helping others.

The key to finding work is to find a need and fill it, so I decided to become a specialist in research synthesis. With my doctoral committee's approval, I proposed a dissertation which incorporates two research syntheses on research questions on vapour devices (e-cigarettes). They kindly assigned research synthesis methodologies as one of my comprehensive exams, which allowed me to spend several months reading up on the many new types of systematic reviews, and to hone my skills. My co-supervisor Dr. Marjorie MacDonald and I obtained a CIHR grant to conduct a meta-narrative analysis on harm reduction and vapour devices. A little later Dr. Lynne Young invited me to the JBI meetings, and it feels so good to engage with other researchers and grad students who know the value of research synthesis for promoting health and best practices.

So as I enjoy finishing my dissertation, I am looking forward to hanging my shingle as a research synthesis service and doing more of my favourite research task for other research teams. Getting paid to learn and share information – wow, my dream job.

SUCCESSES

Congratulations to **Jane Milliken,** on her Honorary Lifetime Membership award at WRNCASN.

Jane is currently a Profesor Emeritus in the School of Nursing. Before retiring in June of 2012, she was the Associate Director Undergraduate Education for the School of Nursing. During this time she undersaw the Continuing BSN program (final semesters of the CAEN curriculum) for students who enter the program in January of their third year and the Post RN Diploma BSN distance program.

Outside the School of Nursing, Jane has completed several accreditation reviews of nursing programs across Canada and internationally for the Canadian Association of Schools of Nursing, and am the board president of the BC Schizophrenia Society - Victoria branch. Recently she helped lead the CASN review of the School of Nursing.

PUBLICATIONS and PRESENTATIONS – FACULTY

Marcellus, L., Loutit, T., & Cross, T. (2015). National survey of NICU practices for infants with Neonatal Abstinence Syndrome. Advances in Neonatal Care, 15(5), 336-344.

Tschanz, C., Thoun, D., Bruce, A. (2016, February 17-19). Contemplative perspectives: Synergy among teaching-learning, inquiry and practice. (Poster presentation). Western & Northern Region Canadian Association of Schools of Nursing Conference, Nursing Education: The Synergy of Teaching, Research, & Practice. Delta Bessborough, Saskatoon, Saskatchewan

PUBLICATIONS and PRESENTATIONS – STUDENTS and ALUMNI

Kira Antinuk, will be presenting "A Historical and Medical Critique of Circumcision/Intact Babies: Avoiding Clinical Errors," at the 2016 Healthy Mothers Healthy Babies conference, sponsored by the Provincial Health Services Authority and organized by UBC, on March 12th. More information is included on page 10 of the conference brochure http://interprofessional.ubc.ca/HealthyMothersHealthyBabies2016/hmhbbrochure.pdf

Kira will also be presenting a keynote presentation with Dr. Christopher Guest, at an evening event in Vancouver at the SFU Harbour Centre on March 9th. The event is titled "Feminist & Medical Critiques of Circumcision" and full details can be found here: http://www.sfuamb.com/

Jacobs, S., Atack, L., Ng, S., Haghiri-Vijeh, R. & Dell'Elce, C. (2015). A peer mentorship program boosts student retention. Nursing 2015, 45(9), 19-22.

Steven Jacobs has also had his abstract selected for oral presentation at the upcoming Nursing Research Conference. His presentation "A process of study selection within a scoping review of nursing student peer mentorship," will act as our first live pilot of a distance presentation by a School of Nursing student. **Abstract:** This presentation describe a recent scoping review I conducted on the topic of nursing student peer mentorship. The objective for this scoping review was to examine the following research question: What is known from existing literature about the extent to which student peer mentorship is prevalent in nursing education?

Joly, E. (in press). Integrating Transition Theory and Bioecological Theory: A theoretical perspective for nurses supporting the transition to adulthood for young people with medical complexity. Journal of Advanced Nursing. doi: 10.1111/jan.12939

Joly, E. (2015). Access to services for young adults with medical complexity. Nursing Ethics. Published online ahead of print. doi: 10.1177/0969733015602053

Joly, E. (2015). Transition to adulthood for young people with medical complexity: An integrative literature review. Journal of Pediatric Nursing, 30(5), e91-e103. doi: 10.1016/j.pedn.2015.05.016

Schick-Makaroff, K., **Antonio, M., Petrovskaya, O**., & Bandsmer, J. (2016). Use of electronic patient-reported outcomes (ePROs) in real time with home dialysis patients and nurses. Invited webinar presentation for COACH (Canada's Health Informatics Association) Clinical Forum: Canadian Telehealth Forum, January 13, 2016.

GRANTS and FUNDING – FACULTY

Scientific Evaluation of Nurse-Family Partnership in British Columbia. Co-PIs: Charlotte Waddell, Harriet MacMillan, CoPIs: Susan Jack, Debbie Sheehan, Nicole Catherine. Co-Investigators: Michael Boyle, Ronald Barr, Colleen Varcoe, **Lenora Marcellus**, Andrea Gonzales, Amiram Gafni, Lil Tonmyr. British Columbia Ministry of Health and Ministry of Children and Family Development (2011-2021), $1,800,000 extension grant

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EDITOR and DESIGN
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