Articulating the Role of the Clinical Nurse Specialist in New Brunswick

Serena Jones Charbachi, RN, BSc, BN
Graduate Student, University of New Brunswick
Fredericton, NB

Claire Williams, RN, BSc, BN
Graduate Student, University of New Brunswick
Fredericton, NB

Dianne McCormack, RN, PhD
Professor, Department of Nursing & Health Sciences
University of New Brunswick
Saint John, NB

In partnership with the Clinical Nurse Specialist Advisory Committee
Horizon Health Network, New Brunswick

Abstract
The clinical nurse specialist (CNS) role is often misunderstood and underutilized. Through partnership with the CNS Advisory Committee in the Horizon Health Network and the Masters of Nursing Program at the University of New Brunswick, the authors developed a clear articulation and visual representation of the CNS role in New Brunswick. This paper synthesizes information gleaned from interviews with the clinical nurse specialists working within Horizon Health Network and integrates this information with the published literature and the position statement of the Canadian Nurses Association (CNA). Vision, voice and value emerged as key considerations, as did barriers to, and successes of, the CNS role. This paper contributes to the acquisition of knowledge regarding the role of the CNS according to the CNA and current published literature. It further promotes an understanding of the important role of the CNS in the healthcare system in New Brunswick, and introduces strategies that can be utilized by clinical nurse specialists to demonstrate value and support the continuation of the role.
The clinical nurse specialist (CNS) is an essential piece of the healthcare puzzle. One of the most important advancements in the nursing profession is the development of the CNS role. This advanced practice role was developed in response to changing healthcare environments and client needs in the 1940s in the United States (Lewandowski and Adamle 2009) and in the 1960s in Canada (Bryant-Lukosius et al. 2010; DiCenzo et al. 2010; Kaasalainen et al. 2010; CNA 2008). The CNA (2009) and the Nurses Association of New Brunswick (NANB 2007) require the CNS to have an advanced degree at either the master’s or doctoral level and to engage in expert practice that includes the following five components: clinical practice, consultation, education, leadership and research. The CNS is required to practise these five components within three spheres of influence: the patient/client sphere, nurses and nursing practice sphere and organization/system sphere (Lewandowski and Adamle 2009).

Despite the fact that CNSs are long-established members of the healthcare team, their role continues to be underutilized and misunderstood by hospital administrators, nurses and allied healthcare professionals (Bryant-Lukosius et al. 2004, 2010; DiCenzo et al. 2010; Donald et al. 2010; Lewandowski and Adamle 2009). Clinical nurse specialists themselves have difficulty articulating what they do and how their activities bring value to the healthcare system. As such, CNSs could be vulnerable to cutbacks, and vacant CNS positions might not be reposted (Bryant-Lukosius et al. 2010). CNSs in the Horizon Health Network in New Brunswick have formed the Clinical Nurse Specialist Advisory Committee (CNSAC) to develop role clarity and address and improve the understanding of this important yet underutilized healthcare role.

Articulating the CNS Role through Partnership
The CNSAC was in its formative stages and, as such, its first task was to articulate and clarify the CNS position within New Brunswick’s healthcare system. A representative from the University of New Brunswick Masters of Nursing (MN) Program was invited to join CNSAC, resulting in an innovative partnership: Masters of Nursing students who were expected to gain an in-depth understanding of the CNS role worked collaboratively with CNSs in the articulation of the role.

In order to understand the CNS role, CNSs provided MN students with copies of their job descriptions and participated in face-to-face or telephone interviews with the MN students. A semi-structured interview guide was used to gain an understanding of the discrepancies between their vision and the reality of the role, barriers to achieving their vision, and their stories of success and how these were measured. Although these interviews generated primary data, the interviews were conducted as expectations of the partners within the partnership and not as participants in a research study. Patterns or themes were identified in the primary data.
As the authors simultaneously conducted a search of the published literature on the role of the CNS, this information was integrated with the emerging themes of the interviews as well as with the CNA's description of the role. From here, a clear articulation of the CNS role was developed:

A CNS is an advanced practice nurse with graduate-level education. The CNS role encompasses five components including that of clinician, consultant, researcher, educator and leader. The focus of the CNS role may change depending on the needs of nurses, patients and their families in that specialty area. Practising within the scope of a CNS, [the nurse] addresses issues at the system level to create an environment that supports quality patient care and enhances client outcomes.

Further, the authors used the synthesis of information from all sources to create an original visual representation of the CNS role. Figure 1 depicts the five components of the CNS role in the inner portion of the circle. The outer portion of the circle provides a description of what the CNS is likely to do in each of these components. Clinical nurse specialists may utilize this visual representation to help them articulate their role. For example, as a clinician, the CNS provides expert client care for patients with complex care needs. The CNS may facilitate this care through the development of clinical pathways. As an educator, the CNS provides education for nurses, allied healthcare professionals, clients and family members. The consultant component of the CNS role involves acting as consultants to nurses, allied healthcare professionals, clients and family to influence policy at the organizational level. The CNS is also a researcher who not only incorporates evidence into practice, but generates and disseminates new knowledge to improve client care and health outcomes. As a leader, the CNS is a role model who acts as a change agent to advance nursing practice. Members of the CNSAC validated that the visual representation was an accurate depiction of their role.

Vision, Voice and Value

Using “vision, voice and value,” identified by Prevost (2002) in her keynote address at the Sixth Annual National Association of CNSs conference in Atlanta, Georgia, USA as a guide, we found that these major themes resonated with the themes that emerged from the interview data with New Brunswick CNSs. The interview data revealed that CNSs not only had a vision for their present role and the future development of the role, but they also recognized barriers to, and the need for collegial support in, fulfilling their role.

Vision

Prevost has stated that “a vision is a necessary criterion for success” (2002: 119). CNS students must graduate with a vision to lead nurses in advancing nursing
practice. Each of the CNSs interviewed described their visions for the CNS role and indicated that vision was essential to guide the direction of the role, a notion supported by Bryant-Lukosius and colleagues (2010). The predominant vision that emerged from the interview data was to have a clearly articulated CNS role within New Brunswick. The CNSs hoped that a clear articulation of their role would increase visibility and understanding among nurses, nurse managers, administration, physicians and other healthcare professionals. While the five components comprising the CNS role were described by some as broad, most CNSs interviewed indicated that depending on the needs of the client population and the nurses providing care, one component of the role took priority over other components. As well, the CNSs interviewed envisioned that increased power within the CNS role would enable them to be more adept in addressing gaps in practice and thus improve client care in a more timely fashion.

**Figure 1.** Visual representation of the CNS role in New Brunswick
The CNSs also indicated that future development of their role would focus on increased involvement in research and writing for publication, a perspective that was echoed in the literature (Bryant-Lukosius 2010; Dhuly et al. 2007; Tuite and George 2010). In addition, CNSs pointed out and confirmed that improved interprofessional relationships were needed in order to continue the development and understanding of the CNS role (DiCenso et al. 2010; Donald et al. 2010).

**Collegial support**
The CNSs who were interviewed considered the support of physicians and administrators as important to the success of the role. More importantly, the interviewees identified the support of the nurse manager as crucial to this success. While CNSs did not report to nurse managers, they were expected to work collaboratively with them and depended on their support to implement changes requiring the cooperation of nurses.

**Barriers**
Our interviewees identified real and potential barriers that could hinder the vision of the CNS role from enactment, for example, lack of support from nurses, nurse managers, administrators and physicians; lack of time; and lack of role clarity, contributing to a poor understanding of the role among healthcare professionals at all levels. The barriers identified by our interviewees were consistent with those cited in the literature (Bryant-Lukosius et al. 2004, 2010; Donald et al. 2010; Lewandowski and Adamle 2009; Mayo et al. 2010; Urquhart et al. 2004).

The most commonly cited barrier by the interviewees was the lack of understanding (and in some cases support) from the nurse manager. This barrier was a common theme in the literature, often leading to job dissatisfaction and, in some cases, CNSs leaving the position altogether (Bamford and Gibson 2000; Carter et al. 2010; Gibson and Bamford 2001; Lloyd Jones 2005; Mayo et al. 2010).

Lack of support and understanding of the role among nurses was a barrier to CNS practice and vision. As Lewandowski and Adamle (2009) have suggested, most of a CNS’s work is accomplished in isolation, and other nurses may not realize that best practice guidelines integrated into policies and procedures were developed by the CNS. Physicians and administrators were commonly identified as barriers to CNS practice by the CNSs whom we interviewed. Again, this situation might be related to a lack of understanding and knowledge about the CNS role in advancing practice and improving specialized client care (Bryant-Lukosius al. 2010; Donald et al. 2010; Lewandowski and Adamle 2009; Mayo et al. 2010).

Lack of time, a frequently cited barrier to practice, was viewed as multifaceted. CNSs interviewed admitted that multiple job expectations that were not consistently
appropriate for the role contributed to a lack of time in fulfilling the components of their role. For example, being responsible for unit orientation took precedence over evaluating the consistent application of best practices. The job expectations that were not appropriate for the role could be attributed to lack of understanding of the role (Lewandowski and Adamle 2009; Mayo et al. 2010). The published literature and all CNSs interviewed confirmed that lack of time impeded research and knowledge development (Gibson and Bamford 2001; Profetto-McGrath et al. 2007).

**Voice**
Clinical nurse specialists must be able to describe how their role differs from that of other nurses and how their contributions add value to healthcare. According to Prevost (2002: 120), “verbalizing the vision is the first action toward achieving it [and] articulating the role of the CNS begins with an elegant description.” The partnership between the CNSAC and MN students was developed to articulate and clarify the CNS role. Voice, or a clearly articulated role, was seen as an antecedent to the role being understood and utilized to its full scope. Voice was the vehicle through which the value of the CNSs’ expertise was made known, enabling CNSs to influence issues of concern within the healthcare system. While articulating the role of the CNS was described as a challenge, our interviewees identified this ambiguity as an aspect of the beauty and uniqueness of their role. Clinical nurse specialists realized that clear articulation of the CNS role could facilitate their voice and subsequently their influence in developing and shaping the future direction of the role in New Brunswick.

**Value**
Porter (2011) has defined value as health outcomes per dollar spent. Yet within the healthcare system, value has remained unmeasured and misunderstood. Value has been measured by the volume of services delivered rather than health outcomes achieved. In order to measure true value, client outcomes and costs must be tracked longitudinally (Porter 2011).

**Demonstrating value**
The CNSs we interviewed related that justifying their positions, especially when first entering the role, was key. One strategy to strengthen nurse value for stakeholders and policy makers included showcasing the important contributions that CNSs made within the Canadian healthcare system. To accomplish this goal, the CNSs demonstrated clinical effectiveness through measuring, communicating and marketing their effectiveness, impact and outcomes (Bryant-Lukosius et al. 2010; Cool and Riddell 2006; Kurtzman 2010; Prevost 2002).

**Outcomes measurement and baseline data collection**
Clinical nurse specialists must implement a system for documenting and report-
ing processes and outcomes. One strategy suggested the comparison of baseline and outcome data (using existing data, such as chart audits, whenever possible). Baseline data established a comparison group and identified clinical targets for the CNSs who used the data to demonstrate the prevalence of adverse events within their clinical setting and the effect of CNS interventions on these events (Prevost 2002). Furthermore, compiling cumulative data that pooled productivity and outcome information would validate value within departments and institutions, and across provincial health regions. CNSs must track the time required for processes and outcomes into cost savings. These outcomes must be reported within the institution as well as in the professional literature. Documentation of high-quality outcome data on CNS impact will likely yield impressive results (Bryant-Lukosius 2010; Bryant-Lukosius et al. 2010; Prevost 2002).

**Data collection tools**
Productivity logs have been used to keep the documentation process from becoming too time-consuming. Prevost (2002) has identified Microsoft Access® as an effective method of capturing and standardizing CNS activities and interventions. Using this program, CNSs were able to capture and compile data that were then stored in a central repository. The compilation of data required the minimal effort of five to 10 minutes per day. Prevost has outlined that for many of the interventions, formulas to calculate cost savings were programmed into the system so that real-time figures could be generated and presented.

Both Prevost (2002) and our interviewees indicated that job satisfaction was derived from the CNS’s impact on quality of care. However, hospital administration was interested primarily in economic savings. In performing cost savings analyses, it is necessary for CNSs to include the costs of complications that are averted as a result of CNS intervention. In order to demonstrate the cost savings aspect of their work, CNSs might need to solicit help from financial experts or other CNSs who have previously undertaken cost savings analyses (Prevost 2002). CNSs across New Brunswick could demonstrate enormous cost savings through decreased neonatal intensive care unit (NICU) admissions, decreased length of stay for hip and knee surgery clients, decreased cost of treating pressure ulcers and decreased surgical infection rates.

**Contributions of the CNS to High-Quality Client Care**
The CNSs who were partners in this exploration of their role had numerous success stories, but these successes were described as “just doing my job.” While it was a challenge to elucidate their success stories, which were often not recognized as such, it was evident that these CNSs had a significant impact on client care and the healthcare system as a whole. The CNSs we interviewed had initiated:
• provincially and nationally adopted programs;
• pre-operative orthopedic education sessions that decreased length of post-operative stay and improved pain management;
• neonatal glucose screening changes that decreased NICU admissions;
• development of a palliative hospice;
• guidelines for stroke care;
• a cost–benefit analysis to demonstrate the advantage of pre-operative clipping versus shaving; and
• policies to ensure that clients have the most up-to-date evidence-based care.

The successes listed here represent a portion of the value that these CNSs have brought to the New Brunswick healthcare system. Clearly, CNSs understood the importance of evaluating programs and policies to ensure sustained changes in practice and to demonstrate effectiveness, but were less likely to take credit or be given credit for their accomplishment.

From this synthesis of primary and secondary data, it became evident that the CNS role is an important piece of the healthcare puzzle. For this reason, the authors created Figure 2 to illustrate the important contributions that CNSs make to the healthcare system and to demonstrate that without CNSs an essential piece of the puzzle would be missing. Clinical nurse specialists improve patient care through the translation of knowledge into practice and advancement of the nursing profession. CNSs role-model expert client care and are respected for their expertise by other nurses. As consultants, CNSs are resources for nurses, nurse managers and physicians in addressing patients’ complex care needs. As change agents, CNSs lead and facilitate change at the systemic level. CNSs have the leadership skills to lead the nursing profession into the future. As researchers, CNSs utilize research to inform practice and policy changes, and some generate new knowledge through primary and secondary research. Through policy and program development, CNSs develop policies and programs to help improve care for patients and their families. Policy changes reduce infection rates, decrease admissions and reduce hospital lengths of stay, all of which save money.

**Conclusion**

Clinical nurse specialists demonstrate value through significant contributions to the healthcare system, including improved client care and better health outcomes for clients. Finally, the process of developing the partnership between MN students and the CNSAC, defined as an interpersonal relationship between two or more parties working towards common goals, identified specific principles of partnership including mutual goals, timing, need, sharing of resources and reciprocal capacity building (McCormack et al. 2010; Murray et al. 2010). The result was a clear articulation of the CNS role for both existing and budding CNSs.
Perhaps even more significant was the recognition of the CNSs’ important contributions to improved client health and the healthcare system as a whole.

The success stories presented in this paper demonstrate that CNSs are essential to high-quality healthcare delivery. With a clearer articulation of the CNS role, understanding will improve and subsequently lead to increased support for the role and increased collaborations with partners within and outside the health sector. Collaboration will enable CNSs to practise to their full scope, to continue to bring value to healthcare and to advance nursing practice and client care. Articulating the CNS role and documenting CNS outcomes will ensure that the value of the CNS is acknowledged, utilized and respected. Undoubtedly, as vision and role definition are articulated through voice, the value of the CNS will increase. In this new era, nurses will gain interest in pursuing the CNS role and administrators will develop new CNS positions. Ultimately, increasing access to CNSs will improve the quality of healthcare care not just for New Brunswick residents, but for all Canadians.

Acknowledgements
The authors wish to thank Luc Drisdelle, Patti Gallagher, Jackie Gordon, Beth Harris, Vivian Leblanc, Monique Levesque-King, Patty McQuinn, Shyanne Reid
and Nancy Schuttenbeld for their willingness to share their CNS experiences. The success of this partnership, which led to a clearer articulation of the CNS role within New Brunswick, would not have been possible without these nurses’ investment of time and knowledge.

Correspondence may be directed to: Serena Marie Jones Charbachi, 5 Dewitt Acres, Fredericton, NB, E3A 6S3; e-mail: serena.jones@unb.ca.

References


