



THE CLINICAL NURSE SPECIALIST IN NEW ZEALAND: HOW IS THE ROLE DEFINED?

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Abstract

New Zealand, like many countries, is developing new advanced nursing practice roles to meet emerging needs. While much has been written about the Nurse Practitioner (NP), the role of Clinical Nurse Specialist (CNS) remains relatively unexplored and lacks national definition. This paper reports the findings from research designed to investigate the role of the CNS and how it is defined by New Zealand District Health Boards (DHBs). The study sought to identify the current requirements and expectations for the CNS role and how it is defined in practice. In 2008, 15 CNS job descriptions were collected from eight DHBs throughout the country generating data that were treated both quantitatively and qualitatively. Overall, few areas of consensus were found regarding the essential requirements for the CNS role and there were inconsistencies in how the roles were defined, most notably concerning requirements for postgraduate qualifications and Professional Development Recognition Programmes. Thematic analysis of the documents generated four key areas relevant to the CNS role. These described the CNS as a leader, a clinical expert, a co-ordinator and an educator. The findings indicate that the CNS role is inconsistently defined in New Zealand, particularly with respect to the postgraduate qualifications required and what is meant by 'expertise'.

Key Words: Clinical nurse specialist, advanced nursing practice, clinical expert.

Introduction

The concepts of advanced nursing roles and specialisation in nursing practice are not new, and they remain internationally relevant issues (Hamric, Spross, & Hanson, 2005; Jacobs, 2007). It is widely acknowledged that advanced nursing practice roles make valuable and positive contributions towards achieving better health outcomes for a variety of patient populations (Gardner, Carryer, Dunn, & Gardner, 2004). Much has been written about the newly established Nurse Practitioner (NP) role in New Zealand, but considerably less about the Clinical Nurse Specialist (CNS) who operates within many New Zealand District Health Boards (DHBs).

It is unclear when CNSs became widely employed throughout New Zealand DHBs, although the title was

mentioned in the New Zealand Nurses' Association policy statement as early as 1976. It appears that the CNS role became fairly common in the late 1990s with key discussion about it appearing in the report of the Ministerial Taskforce on Nursing (1998). In 1998 the Nurse Executives of New Zealand released a role definition which stated,

A Clinical Nurse Specialist role is undertaken by a nurse with experience in the clinical specialty and advanced learning in that area of specialist cares. The nurse, during episodes of care, undertakes assessment, organizes tests, plans and initiates

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care to meet the special needs of an individual or group of patients with particular health problems (Peach, Cooper-Liversedge, Russell, & Hayes, 1998, p.3).

The CNS role is now widespread throughout New Zealand and is deemed a senior nurse role in the DHB Multi-Employer Collective Agreement (MECA) (New Zealand Nurses Organisation, 2007). However, although there are many CNSs employed by DHBs around the country, the role remains unclear and lacks national definition.

Literature Review

Internationally the concept of specialised expert or advanced nursing is not new and can be identified as early as the nineteenth century in the United States Civil War (Hamric et al., 2005; Jacobs, 2007). Advanced nursing practice, however, became decisively established in the USA in the 1970s through advances in educational preparation and clinical practice roles for both the CNS and NP (Hamric et al.). The contemporary CNS role is also established in Australia, Taiwan, China, Japan, New Zealand and the United Kingdom (Chen, 2009; Hamric et al.). In each country, the definition and practice scope of the CNS role are influenced by factors such as the national economy, culture, education and practice standards, and models of health care delivery (Chen; Hamric et al.). Currently in New Zealand the most obvious example of the advanced practitioner is the NP, and much has been written about this role and its contribution to health care (Dunn, 1997; Gardner et al., 2004). However, the specific role and contribution of the CNS in New Zealand remains much less explored.

Based on internationally and nationally accepted definitions, the CNS role falls under the umbrella of advanced nursing practice. The International Council of Nurses (ICN) states,

A nurse practitioner/advanced practice nurse is a

registered nurse who has the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master's degree is recommended for entry level (ICN, 2005, p. 5).

The Nursing Council of New Zealand defines advanced practice as that which "reflects a range of highly developed clinical skills and judgments acquired through a combination of nursing experience and education" (ICN, 2005, p. 4).

Elsewhere, a CNS is defined as a Registered Nurse (RN) who, through both practice and masterate level education, has become an expert in a clinical area of nursing (Sparacino, 2005). The American Nurses Association (1996) defines the CNS as an, "expert clinician and client advocate in a particular specialty or subspecialty of nursing practice" (p. 3). In the literature there appear to be commonalities about what constitutes 'expert'. The qualities most often referred to are: expert delivery of care; facilitating change and quality improvements; education of self (postgraduate) and in the workplace to colleagues and patients; active involvement in research; functioning as a leader; and cultural and ethical fluency (Borbasi, 1999; Castledine, 1999; National Nursing Organisations New Zealand, 2005). The most important quality is considered to be the delivery of expert care (Benner, 1984; Patterson, 1987). More recently it appears that emphasis is shifting from the delivery of care to the multitude of roles the expert is additionally expected to fulfil, such as leader, researcher, teacher, change agent, policy writer and professional spokesperson (Castledine; National Nursing Organisations New Zealand).

Hamric et al. (2005) describe several competencies integral to the CNS role. These include clinical practice, coaching and guidance, consultation, research,



leadership, collaboration and ethical decision making. There is emphasis on the direct patient care component of the definition, as clinical practice, skills, knowledge and clinical wisdom are said to be the core of CNS practice (Sparacino, 2005).

Benner (1984) suggests there is a wealth of untapped expert knowledge embedded in the practices and know-how of expert nurses that remains unrealised until it can be articulated by nurses. Changes in New Zealand legislation, such as the Health Practitioners Competence Assurance Act (2003), professional/ industrial negotiations (for example, the MECA) (New Zealand Nurses Organisation, 2007) and the national use of the Professional Development Recognition Programme (PDRP), have contributed significantly to addressing this lack of articulation in New Zealand.

There has been much debate about merging the NP and CNS roles (Elsom, Happell, & Manias, 2006; Gardner et al., 2004) as they share many commonalities such as research, education and consulting (Henderson, 2004). The literature, however, suggests fundamental differences in the roles; NPs are, "responsible for diagnosing and managing" while CNSs care for patients with, "already identified health problems" (Gardner et al., p. 11). Dunn (1997) suggests, in the American setting, a NP provides more comprehensive care than a CNS but this could be due to the difference in their patient populations. CNSs generally care for patients in acute hospital settings and NPs are more likely to be in primary health. In New Zealand this is not the case. NPs are registered to work in both acute hospital settings and in primary health and, according to Harris (2007), it appears more are working in acute hospital settings.

In Australia the title CNS refers to a promotional position on a clinical career pathway. The establishment of the CNS role was driven by industrial processes and linked to financial progression, to "enable nurses to progress professionally without having to leave the bedside to

take up positions in education or ... administration" (Elsom et al., 2006, p. 57). Yet it appears that both educative and administrative duties are an integral part of the CNS role in Australia. Duffield et al.'s (2005) study of the roles found that CNSs spent more time engaged in managerial and clerical activities than the RN. This disproportionate amount of indirect care contradicts their defined role. Both Duffield et al. and Scott (1999) show role confusion remains an issue for CNSs.

LaSala, Connors, Pedro, and Phipps (2007) surveyed RNs and CNSs to determine how CNSs are utilised at a large US teaching hospital. The survey aimed to describe the role and its impact on patient outcomes. They found that the CNS role at the hospitals they studied consisted of expert clinical care, and teaching and coaching staff, but they also described ways the role influenced patient outcomes. They concluded the CNS may be seen as a dispensable luxury if those holding the position are unable to articulate their role and the unique contributions they make to patient outcomes and the reduction of health care costs (LaSala et al.).

In the United Kingdom Bousfield (1997) described the CNS role similarly to the US, as, "advancing knowledge, expertise and leadership skills" (p. 245). However, Bousfield found the CNSs potential was not being reached as many of those in the roles described organisational barriers restricting their ability to practise autonomously, as well as feelings of burnout, isolation and role conflict.

There does not appear to be a clear definition of the CNS role in New Zealand. Patterson (1987) explored the potential contribution the CNS role could make to the acute setting in New Zealand, but there has been little else written about the role since even though it is clear the title is in use. The New Zealand Nurses Organisation (NZNO) has a position statement on advanced nursing practice but it does not specify any role other than NP. The national PDRP working party report to the National



Nursing Organizations New Zealand (2005) recommends national role titles. These include advanced clinical titles such as ‘Nurse Specialist’. Since this report, the District Health Boards/NZNO Nursing and Midwifery Multi-employer Collective Agreement (MECA) (NZNO, 2007) has expanded the role designation and national titles. CNS is included and loosely defined as having a focus on patient care delivery, providing specialist care and expertise, supporting nursing staff to provide expert care, and having a role in research and policy and procedure development (NZNO). Adding to the confusion, the MECA defines a ‘Specialty Clinical Nurse’. This role appears to involve the same level of expertise and direct patient care as the CNS, but MECA stipulates that the Specialty Clinical Nurse has a narrower focus and does not include a research component (NZNO). Amidst this confusion, research was undertaken to investigate how the CNS role is defined in New Zealand through an analysis of job descriptions for CNS positions as advertised by New Zealand DHBs.

Method

This research was a descriptive exploratory study investigating the characteristics of the CNS role in New Zealand, as defined by CNS job descriptions provided by New Zealand DHBs. The purpose was to understand how the CNS role is defined by New Zealand DHBs, to describe the qualifications, qualities, characteristics and expectations as communicated by DHB definitions, and to contribute to national knowledge and discussion about this advanced nursing practice role.

Data collection.

In 2008, the Human Resource (HR) departments of eight DHBs throughout New Zealand were approached and invited to supply documents describing CNS jobs within their Board. They included Central Region DHBs (Hawke’s Bay to Wellington), for which the researchers had access through a regional network, and the main tertiary centres (Auckland, Waikato, Canterbury and

Otago). This sample provided a geographic spread and a range of regional and tertiary hospitals. Job descriptions are readily available public documents but, regardless, all HR departments were told the purpose for which the documents were being requested.

In total, thirty-two documents describing CNS position were provided. These were either generic CNS job description templates or job descriptions written for a specific specialty position. Of the total, fifteen were selected for analysis. The remaining seventeen were excluded either because the titles of the job described did not exactly match the CNS role under study (for example, Clinical Midwife Specialist or Clinical Nurse Leader), or because they were duplications of a job description already included in the analysis, differentiated only by the specific job title. Details of the job descriptions and their DHB of origin are summarised in Table 1. All DHBs that provided documents are included in the Table.

Table 1.
Summary of New Zealand DHB CNS Job Descriptions Used In Study.

District Health Board:	Number of job descriptions:
Auckland DHB	1- generic CNS job description
Waikato DHB	1- specific CNS job descriptions
Hawke’s Bay DHB	2- specific CNS job descriptions
Mid-Central DHB	3- specific CNS job descriptions
Taranaki DHB	1- specific CNS job description
Wairarapa DHB	3- specific CNS job descriptions
Capital & Coast DHB	3- specific CNS job descriptions
Canterbury DHB	1- generic CNS job descriptions

Ethical issues.

As the research collected and analysed public documents no specific ethical consents were required.



Data analysis.

Analysis of the job description documents required data to be treated both quantitatively and qualitatively to provide a fuller understanding of the CNS role as defined by New Zealand DHBs. With the number of documents being only fifteen, the quantitative analysis warranted simple descriptive statistics. Frequencies of reported CNS role requirements were summed and tabulated. These were also calculated as percentages of the whole, thus providing an impression of respective proportions. A template was used to reliably execute this analysis.

Other aspects of the CNS job descriptions required the data to be treated qualitatively. This refers to sections of the documents where 'statements of the purpose of the role' were described in one or two paragraphs, and the 'key performance indicators' were one or two page lists of expected day to day nursing practice. For these sections a simple thematic analysis was undertaken, a form of analysis most common in qualitative health research (Pope, Ziebland, & Mays, 2006). This was guided by Thomas's (2006) general inductive approach, whereby "The primary purpose ... is to allow research findings to emerge from the frequent, dominant or significant themes inherent in the raw data" (p. 2). Coding constancy checks were undertaken by the co-researchers and trustworthiness was sought through consultation with stakeholders, being those practising in CNS roles (Roberts, 2009).

The job description documents are publically available for authentication, and extracts from those analysed have been extensively cited below as evidence of the findings. Reliability of the findings was accomplished through inter-rater analysis (Elliot, 2007). The three authors independently reviewed the documents to determine content categories. The study has internal validity in that the template used to analyse the documents provided appropriate data to answer the research question.

Findings

All the analysed CNS job descriptions were found to be similarly formatted in the way the key components of the CNS role were presented. These have been presented below under the sub-headings of qualifications, required experience and purposes of the role.

Qualifications listed as required for the CNS role.

Of the qualifications listed in the job descriptions provided by the DHBs, six were consistently considered essential requirements for a CNS and two were considered desirable. These are presented in Figure 1.

All fifteen (100%) of the job descriptions listed *Registered Nurse with current annual practising certificate* as an essential qualification for the CNS role. This unanimity is unsurprising as it is a legal requirement under the Health Practitioners Competence Assurance Act (2003) that all practising nurses must have a current annual practising certificate issued by the Nursing Council of New Zealand. This is the only requirement where consensus was achieved across all contributing DHBs.

The next most commonly stated essential requirement, in seven (46.6%) of the job descriptions, was *holding or working towards a postgraduate qualification*. The level of qualification (i.e. postgraduate certificate, postgraduate diploma, Master's degree, or doctoral degree) was not specified in any of the job descriptions, nor was any preferred discipline (such as nursing, management, or any other) specified for the qualification. Two (13.3%) of the job descriptions considered a postgraduate certificate or diploma in specialty nursing to be an essential qualification for the CNS role.

In total, only nine (59.9%) of the job descriptions required the CNS to be working towards or holding some form of postgraduate qualification. More surprisingly, in four cases (26.6%) there was no mention at all of a

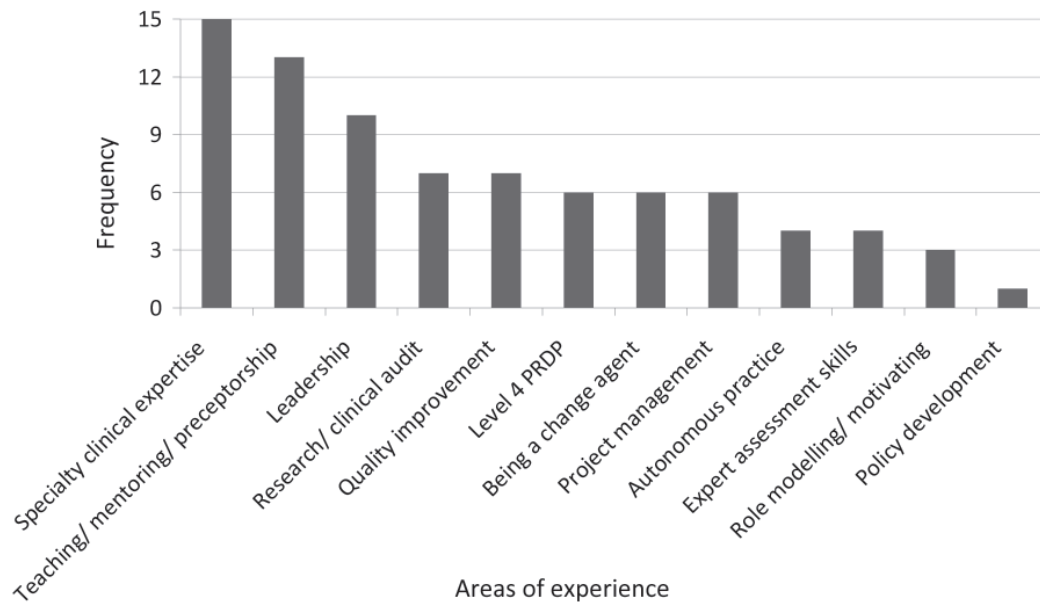


Figure 1. Areas in which experience was listed as being required in clinical nurse specialist job descriptions (n=15)

postgraduate qualification as being essential for the CNS role. This finding is significant because all the reviewed literature, national and international, stated that the CNS role requires preparation at the postgraduate level.

The third most commonly cited essential qualification for a CNS, listed in four (26.6%) of the job descriptions, was a *New Zealand driver's license*. This was followed by *computer literacy* (20%), although a level of literacy was not specified nor was competency in any particular computer programme. Arguably in this context, 'computer literacy' is not a qualification per se, but more a skill in which people have variable levels of competence.

Two (13.3%) of the job descriptions specified that the CNS should be *holding or working towards level four on a Professional Development Recognition Programme (PDRP)*. This is interesting as PDRP participation is a voluntary exercise for nurses, not a legal requirement of the NZ Nursing Council. Two further qualifications were listed in the job descriptions as desirable, as opposed to essential, for the CNS role. These were *adult or clinical*

teaching qualification (2, 13.3%, level unspecified), and *holding or working toward a clinical Masters* (3, 20%).

Areas of experience listed as required for the CNS role.

The following section outlines the areas in which experience was listed in the job descriptions as required for the CNS role. The types of experience were in list format in the analysed documents and their frequencies per job description were collated. The results are presented in Figure 2.

All fifteen (100%) of the job descriptions specified clinical experience in the specialty area as a requirement, although the amount of experience was unspecified and not quantified. Thirteen DHBs mentioned qualities that referred to teaching, mentoring or preceptorship roles. These two categories, along with leadership, were the only areas mentioned in more than half of the documents analysed. Six (40%) preferred the CNS to have experience at the level four category, 'Expert Registered Nurse'.

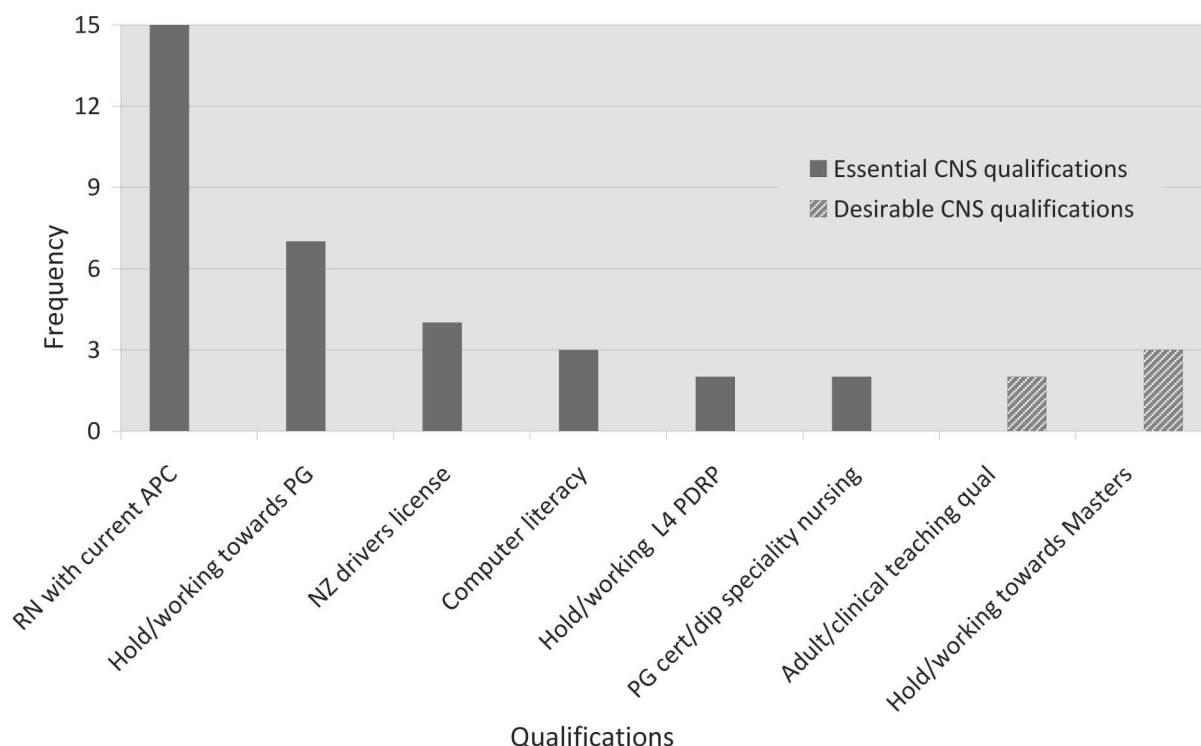


Figure 2. Qualifications listed in job descriptions (n=15) for the clinical nurse specialist role

It appears from these results that the areas in which it is considered the CNS should have experience for the role are varied. The most common areas include specialty clinical experience, teaching/mentoring/coaching and leadership experience, but there are several other key areas which 40 to 46.6% of the job descriptions listed as important, such as research, quality improvement and project management. Overall, the job descriptions listed a broad range of required areas of experience, so contributing further to inconsistencies in the way the CNS role is understood and defined.

Purpose and key indicators of the CNS role.

Thematic analysis was applied to the data relating to the areas where the job documentation referred to the 'statement of purpose of the role' and the 'key performance indicators'. From these, four main themes emerged in which the CNS was described as leader, clinical expert, co-ordinator, and educator. These will be discussed.

The CNS as a leader.

CNSs were described as leaders in several ways, such as leading through role-modelling expert practice, and by example of the CNS's own professional development. Leading by providing excellent care and by coordinating the specialty service were also specified. Extracts from the documents referring to the CNS role in these various ways include:

To promote excellence in nursing practice. (Taranaki DHB)

To provide leadership and development of the ... team, to co-ordinate and lead. (Capital & Coast DHB)

To co-ordinate and manage the referral, consultation, assessment, management and supervision of nursing staff ... role modelling best practice, training and education. (Capital & Coast DHB)

Some job descriptions included aspects of leadership as evident through providing expert care. For example Mid-Central DHB specified: *The CNS functions within*



the specialty providing clinical expertise and leadership that ensures services to clients are provided in the most effective and efficient way.

Similarly, Mid-Central DHB stated: *The CNS will act in the roles of a practitioner, educator, consultant, researcher, change agent and leader in the pursuit of clinical excellence and improved health outcomes.*

Other comments included: *The CNS role models quality nursing practice* (Mid-Central DHB); and *The CNS works within a clinical specialty in the capacity of role model, clinical expert, case manager, change agent, educator researcher and leader.* (Wairarapa DHB)

Canterbury DHB stated: *The CNS is the acknowledged nursing leader within the hospital clinical specialty.* This clearly acknowledges the CNS role as one of leadership, but it also implies that the role is of sole leadership within the specialty and does not acknowledge other nursing leaders with whom the CNS may work, such as the Clinical Nurse Manager or Clinical Nurse Educator. Auckland DHB described the CNS as *a leader, a senior nurse and an advanced nursing practice role.* This is in line with the DHB/NZNO MECA which outlines recommended national senior nurse titles including the CNS (NZNO, 2007).

The CNS as a clinical expert.

As indicated in the DHB job descriptions, the CNS is described as someone who has specialised expert clinical nursing knowledge and uses this to provide both direct and indirect patient care. Direct care is that provided by the CNS directly for the patient. Indirect care is facilitated or directed by the CNS and provided to the patient by another RN or health provider.

It is unclear in the documents how expertise or specialist knowledge is measured by DHBs although 26.6% of the job descriptions listed expert clinical assessment skills as essential experience for the CNS role. Expertise, in the

form of being at or working towards level four (expert) on the PDRP, is listed as an essential qualification in 13.3% of the job descriptions. Forty percent of the job descriptions list experience at level four on the PDRP as being required.

Although it is unclear what constitutes expert clinical practice, all the analysed job descriptions state that the CNS role is that of a clinical expert. Following are two examples:

The CNS works within a clinical specialty in capacity of clinical expert. (Wairarapa DHB)

The CNS is an autonomous practitioner responsible for providing specialist nursing care. (Auckland DHB)

Waikato DHB describes the role of the CNS as: *to provide clinical expertise in assessment, treatment, advice, supervision and education.* Mid-Central DHB echoes this, stating: *The role requires an advanced skill level and theoretical knowledge in a specialized area of practice.* Hawke's Bay DHB provides a description of the purpose of the CNS position: *The focus is on care delivery, providing specialist nursing care and expertise, both in direct care delivery and in support to other staff and community providers in the management of a defined patient group.*

Frequently the words 'expert' and 'specialist' are used interchangeably. For example, Capital and Coast DHB state: *The CNS will provide direct specialist nursing support and expertise for ... patients,* and *The CNS is an expert in the care of patients and is primarily responsible for providing direct expert care.* Further, the CNS has *specialized knowledge and skills* (Capital & Coast DHB).

There was unanimity in the job descriptions defining clinical expertise as an essential component of the CNS role. Clinical expertise was described as specialty skills in care delivery, level four on the PDRP and as expert advisor to other health professionals. However, there



appeared to be inconsistencies in how expertise is measured.

The CNS as a co-ordinator.

The third theme describes the CNS as a co-ordinator of both the specialty service and patient care. The role of co-ordination was distinct from leadership as it focused solely on co-ordination of patient care and the specialty service. The following examples illustrate how the DHBs see the CNS as being a co-ordinator:

The CNS works within the hospital setting and throughout the ... district to co-ordinate care. The CNS has a key focus on the co-ordination of the patient journey. (Mid-Central DHB)

The CNS is, responsible for co-ordinating and providing specialty primary and secondary assessment, prevention, education and intervention. (Canterbury DHB)

Similarly, Auckland DHB states the CNS is: *responsible for providing specialist nursing care and or co-ordination of care to a specific patient population.* Co-ordination of the specialist service was described by Waikato DHB as being: *to co-ordinate an effective and efficient service, to network, integrate and co-ordinate the CHD/community interface.* Capital and Coast DHB also states the CNS role is: *to co-ordinate and lead, and: to co-ordinate the referral of patients to the service.*

There is an obvious expectation reflected in the job descriptions that the role of CNS involves co-ordination of patient care and delivery of that care; and furthermore, that the CNS role extends to co-ordination of the overall specialty service.

The CNS as an educator.

The final theme to emerge from the analysis of the job descriptions was the expectation of the CNS as an educator. The job descriptions outlined the CNS responsible for providing education to patients and families as well as to other RNs and health professionals. This included formal teaching sessions,

policy development and mentoring of staff.

Education extended to patients and their families was an expectation described in the documents from both Canterbury and Waikato DHBs. These included: the CNS functions as a: *resource person, responsible for co-ordinating and providing education for a defined patient population* (Canterbury DHB), and the CNS role is: *to provide or assist in the clinical education needs of patients/carers ... to provide education* (Waikato DHB).

The CNS role as an educator of other nurses and health professionals was described as follows:

The CNS has a key focus on the education of patients and health professionals through facilitation of both formal and informal learning opportunities (Mid-Central DHB). Also: *The CNS provides consultation, support and education for nursing staff, and, actively participate in the development of protocols/policies and guidelines* (Capital & Coast DHB). *The role involves the identification of staff training needs and provision of education sessions that address these needs* (Taranaki DHB).

Education is a major theme of the CNS role, reflected in the descriptions and key performance indicators of the role, and 86.6% of the job descriptions listing experience in teaching/mentoring/preceptorship as desirable (Figure 2). However, a formal qualification in adult education was not a major requirement for the role with only 13.3% listing a qualification in adult education as desirable (Figure 1).

Discussion and Conclusions

This paper has presented the results of an analysis of the content of documents defining and describing CNS positions in New Zealand DHBs. Across the country many inconsistencies were found in how CNS jobs were defined and what was expected of the role. The only two areas in which there was unanimous agreement



were the requirements for the CNS to be a New Zealand registered nurse, with a current annual practising certificate and experience in the specialty area.

There is consensus in the literature that the nursing profession needs to better articulate what is meant by 'expert' and 'advanced practice', and to establish some consistency in role titles in order to better direct practice to meet the needs of the patient community (Bousfield, 1997; Elsom et al., 2006; Hickmott, 2007; LaSala et al., 2007; Ministerial Taskforce on Nursing, 1998). The terms 'expert' and 'CNS' are often used interchangeably and there is apparently considerable confusion in New Zealand surrounding advanced practice roles other than the NP. Indeed it could be said that the CNS is the 'poor cousin' to the NP and, anecdotally, some nurses see the CNS role as a stepping stone to NP.

It is over twelve years since the Ministerial Taskforce on Nursing (1998) identified the importance of advanced practice roles and recommended their development, hence it is surprising that the CNS role remains unclear and ill-defined. The report specifically discussed the need to define and develop both the NP and CNS roles. Emphasis was placed on the CNS role in particular when the report stated,

There is also a need to further develop and support the clinical-nurse-specialist role. This role is undertaken by a nurse who has both substantial experience in a particular specialty and advanced learning in that area of specialist care. The clinical nurse specialist is a crucial member of a health-care team. There are good, but few, examples of this role in New Zealand. These now need to be recognised and endorsed by the Nursing Council (Ministerial Taskforce on Nursing, 1998, p. 29).

It is encouraging to see increasing numbers of CNSs employed. In the Auckland region emergency departments, for example, 15 CNSs were employed over an 18 month period (Geraghty, 2010). There is

a commitment to advanced practice roles and the development of specialist clinical training for emergency CNSs is planned for early 2011 to, "provide a training programme and development process that standardises CNS skills and knowledge" (Geraghty, p. 15).

This analysis has highlighted recurring themes as to what qualities a CNS should possess; but there remains no agreement about how these qualities are measured. A clear, nationally consistent standard of preparation for the role, such as would be provided by Master's level education, may go some way towards addressing the inconsistencies.

While some consistent aspects of the CNS role have emerged, the inconsistencies shown in the DHB job descriptions continue to present a poorly defined picture of the CNS in New Zealand. These problems areas are mainly concerned with how expertise is measured, specifically regarding necessary postgraduate qualifications, and whether or not being levelled 'expert' on the PDRP is an essential process for the role. Until there is more clarity and common understanding surrounding the CNS role in New Zealand it is unlikely to achieve its full potential in terms of contributing to health outcomes.

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