



NATIONAL ASSOCIATION OF
CLINICAL NURSE SPECIALISTS

A Vision of the Future for Clinical Nurse Specialists

Prepared by the National Association of Clinical Nurse Specialists

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***Authors:** Kelly A. Goudreau, DSN, RN, CNS, Chair, NACNS Vision Task Force; Kathleen Baldwin PhD, RN, CNS, ANP, GNP; Angela Clark, PhD, RN, CS, FAAN, FAHA; Janet Fulton, PhD, RN; Brenda Lyon, DNS, RN, CNS, FAAN; Theresa Murray, MSN, RN, CCRN, CNS; JoEllen Rust, MSN, RN, CNS; Sue Sendelbach, PhD, RN, CCNS, FAHA*

Introduction

The membership of the National Association of Clinical Nurse Specialists (NACNS) offers this future vision of CNS practice, education, certification and regulation to inform other professional groups about the importance of advanced practice nursing services provided by CNSs and the structure under which CNS practice should be regulated.

This document details the vision of the membership of NACNS and is intended to guide policy decisions related to the practice, education, certification and regulation of CNSs now and into the future. By clearly articulating the vision that NACNS and its membership has for the future of CNSs, this document will inform other professional groups about the need for advanced practice nursing provided by CNSs as well as the structure under which CNS practice should be regulated.

In February of 2006, the National Council of State Boards of Nursing (NCSBN) released a draft paper detailing its vision for the future regulation of Advanced Practice Registered Nurses (APRNs) (NCSBN, 2006). This vision included statements regarding Clinical Nurse Specialists

(CNSs) that caused distress to CNSs nation-wide. Numerous CNSs as well as members of other national organizations voiced robust support for the CNS role. Letters of strong support for CNS practice were posted on specialty practice websites as well as shared with NACNS and the NCSBN. The release of the NCSBN draft paper and subsequent strong support for the CNS role clearly identified the need for NACNS to articulate our vision of the future for CNSs in a manner that speaks on behalf of our members. A review of the extensive recruitment activities for CNSs nation-wide combined with discussions with leaders from the American Organization of Nurse Executives (AONE) affirmed that the practice, education, and regulation of CNSs will be important well into the future.

Several documents from national organizations were used in the development and refinement of this vision. Both the NACNS *Statement on Clinical Nurse Specialist Practice and Education* (NACNS, 2004) and the American Nurses Association (ANA) *Nursing: Scope and Standards of Practice* (2004) have provided foundational concepts to this document.

Additionally, the concepts in other documents from the ANA, specifically *Nursing's Social Policy Statement* (ANA, 2003) and the *Scope and Standards of Advanced Practice Nursing* (ANA, 1996), informed the development of this document. Practice issues were examined in the context of recent publications from the Institute of Medicine (1999, 2001, 2004) and the Institute for Healthcare Improvement (2004, 2006). Within the education portion of this document, the AACN draft document on the proposed clinical doctorate, the Doctor of Nursing Practice (DNP), was considered (AACN *DNP Essentials, August 14, 2006,*) along with discussions focused on identifying competencies required for clinical practice at the doctoral level for clinical nurse

specialists. These discussions about the implications of doctoral level education for clinical practice were held in July of 2006 at an invitational summit with national specialty organizations containing large numbers of CNSs in their membership. Finally, the content regarding regulation and certification found in past NACNS position statements and white papers, as well as the draft NCSBN Vision Paper (2006), were considered.

The NACNS strongly believes and continues to support the position of the ANA that the CNS is one of four advanced practice registered nursing roles (ANA, 1996; 2004). The future for CNSs is rich, filled with promise, and focused on the provision of advanced practice nursing care to patients in all healthcare settings and across all specialties. CNS practice into the future will ensure that the health care system is safe for our patients and that positive patient care outcomes are attained through collaboration with transprofessional teams of healthcare providers. Clinical nurse specialists will continue to be experts in the synthesis, integration, transformation, and translation of best practices as articulated in the literature. It is the CNS who works within the healthcare system to bridge the gap between what is known through research and what is done in the practice setting. As a consequence, the role played by CNSs will only grow in value over the next two decades. The overall safety of the healthcare delivery system and the patients entrusted to our care are being enhanced daily by the work of the CNS.

CNS Practice in the Future

Clinical expertise in a specialty is the hallmark of CNS practice (ANA, 2004; NACNS, 2004). With the explosion in both practice knowledge and the use of technology, specialization will become even more important. Clinical expertise and specialization of the CNS are founded

on graduate preparation (earned master's, post-master's or doctorate) from a program that prepares CNSs. Clinical expertise within a specialty enables CNSs to provide expert advanced care to patients/clients and to positively affect delivery of care in their area of specialty by developing evidence-based standards of care and bringing them to the bedside. Through the implementation of protocols, pathways, and introduction of new equipment and technology at the point of care, the expert CNS brings specialty care informed by the cutting edge of current knowledge. In addition, a CNS has clinical expertise in diagnosis and treatment used to prevent, remediate, or alleviate illness and promote health within a defined specialty population. Expertise in clinical practice is manifested through the care of individuals, families, groups, and communities and is the core of CNS practice (NACNS, 2004). These foundations of CNS practice have provided strength to the CNS role for more than 50 years. They clearly have stood the test of time and will continue to be relevant into the future.

The CNS provides care to patients by functioning within three key spheres of influence:

- the patient/client sphere,
- the nurses/nursing sphere, and
- the system/organizational sphere (NACNS, 2004).

Clinical quality outcomes associated with each of the three spheres exist and can be used to measure CNS effectiveness in improving health care, both now and in the future. As the population ages and the nursing shortage affects the delivery of care at the bedside, the CNS will work to create clinical practice environments in which staff nurses and other bedside caregivers can practice excellence. The role of the CNS will continue to be focused on the removal of

barriers and on the incorporation of tools for the cost-effective, safety-focused management of patient care. The goal of CNS practice is to achieve the best possible outcomes for the patient, the nursing staff, and the system. The importance of the CNS role in obtaining Magnet status for hospitals is well documented and will continue to be important to leaders in acute care settings. In the patient/client sphere, the CNS provides direct patient care using clinical expertise to assess, diagnose, and treat illness and to promote wellness by reducing risk behaviors through interaction with the other two spheres of influence (NACNS, 2004). CNS specialty practice may occur in acute care settings, private practice settings, or the community. The CNS may provide direct patient care, consult with other nurses about specific patients, and/or modify the plan of care based on evidence-based patient care interventions within the CNS's specialty practice area. Within any consultation with the patient, nursing staff, or system, the CNS may augment the treatment plan by identifying a new protocol or device that will optimize patient/client outcomes. The CNS may also see patients/clients in a private practice and recommend interventions that would enable the patient/client to attain the maximum level of wellness. In the community setting, the CNS consults with patients and their caregivers to facilitate the highest level of function or consults with members or leaders of the community as a whole to provide care with a focus on prevention and wellness. Across all settings, CNS practice may include prescriptive authority, viewed in the broad sense as including consultations with other disciplines, ordering diagnostic tests/surveillance to inform the plan of care, and ordering durable medical equipment to maintain or achieve a higher level of health. Prescriptive authority may also include the prescribing of pharmacologic agents used to augment care (NACNS, 2004). NACNS defines

prescriptive authority as broader than the act of simply writing a prescription and as involving determination of the far-reaching implications and consequences of prescribing on the patient/client, the nursing staff, the organization, and the system.

Healthcare in the future will continue to focus on prevention of disease, maintenance of function, and resolution of functional problems (IOM, 2004). The CNS will continue to integrate theories of health promotion along with evidence-based practice (EBP) to ensure the patient is treated with interventions based on the best science. The development or facilitation of new programs of care to safely decrease length of stay and/or cost of care delivery while maintaining or improving quality of care is essential in the future. The educational preparation of CNSs uniquely qualifies them for this work, which will be critically important to the patients and the health care systems of the future.

With the growing numbers of elders and the general aging of the population, there will be an increased need to provide competent care for older adults in all settings. Included in the direct care for these patients will be cost-benefit analyses to assess if new or existing nursing practices and products are therapeutically efficacious and cost-effective. The CNS is uniquely prepared to do this work.

In addition to clinical expertise in providing care to a specific population, CNSs will also continue to influence patient outcomes by practicing in the nurses/nursing practice sphere through implementation, integration, and translation of evidence-based practice (EBP) into daily operational activities. CNSs are experts at bridging the gap between what is common clinical practice and the state of current science through translation of research into action. As more

healthcare systems, government agencies, and third party payers focus on evidence-based practice (EBP) and patient/client outcomes, the clinical and operational expertise of the CNS will increase in importance. Through the actions of the expert CNS, improvements to the safety and quality of patient/client care and outcomes and system-level improvements that enhance the workplace environment for the nursing staff will occur. This improvement of the workplace environment is a key indicator in attainment of Magnet status for hospitals and is a key outcome of the interface of the CNS with the nurses/nursing practice sphere. The implementation of EBP through eliciting action research questions, mentoring nurses to apply best evidence, and empowering them to ensure that EBP is fully integrated into all professional interactions with patients will continue to be a major component of the work of the CNS.

The final sphere of CNS practice, the organization/systems sphere, will likely see the most significant change for CNSs. CNSs will serve as integrators and collaborators with transprofessional teams of healthcare providers. As health care costs increase, the skill and expertise of the CNS will continue to be used to analyze the cost-effectiveness and cost benefits of new products, interventions, and programs. Across care settings, the CNS will provide expertise in preventing problems such as skin breakdown, falls, and poor nutritional status, which are costly to patients, families, and entities such as Medicare and third-party payers who must provide the financial reimbursement for preventable health problems. In the hospital environment, the CNS will provide expertise in reducing negative, expensive patient care outcomes that are nurse-sensitive, including urinary tract infections (UTI), falls, nosocomial infections, and failure to rescue (Aiken, 2005). The ability of the CNS to problem solve at the

system level and skill in working with multiple disciplines to reach a common resolution to a patient/client care issue will enable the CNS to predict what will occur system-wide with organizational changes. The synergy of working with and leading/coordinating teams of professionals in a highly communicative, focused care environment regardless of setting will continue to be the hallmark of CNS practice into the future. The CNS of the future will continue to be the connector and integrator across the healthcare system.

Increased opportunities in the future in the organization/systems sphere will extend past traditional healthcare settings to settings in which the CNS will mobilize, change, or transform systems to facilitate expertly designed nursing interventions (NACNS, 2004; AACN, 2006). As a change agent, the CNS will work to create this new future. Creating the system in which CNSs lead the nursing staff to practice excellence and achieve therapeutically efficacious, cost-effective outcomes is an essential component of the work of the CNS both now and in the future (NACNS, 2004). Making sure all systems are in place to facilitate both major and minor changes and ensuring that transitions go smoothly to assure positive patient outcomes will be essential at all points of care in the healthcare system. The CNS is uniquely positioned within all sectors of the healthcare system already and will continue to influence changes that will improve practice and ensure high quality, cost-effective patient outcomes (NACNS, 2004).

The CNS of the future also will be involved in examining patient populations and care practices at a broader level, such as within Medicare and Medicaid (CMS) systems. As more care moves into the community setting, increased numbers of community health CNSs will be needed. Future CNSs will influence care practices at the local, national, and international levels.

The expertise of the CNS will be essential in discussion and development of action plans to be enacted in national healthcare crises such as epidemics, national catastrophes, or disasters.

As the global economy expands, so too will healthcare. The reach of future CNSs will extend to international forums where their expertise will be recognized and valued. The education and expertise of CNSs prepare them to function as change agents, collaborators, and system-level thinkers. This expertise allows them to provide cogent and relevant opinions about interventions to streamline organizational operations and improve clinical care, quality, and outcomes throughout the health care system. The CNS of the future will use these skills in national and international settings to improve global health.

Through the interaction of the three spheres of influence, the advanced nursing practice of CNSs will continue to be relevant well into the future. New models of CNS practice will be developed because CNSs will be increasingly innovative and entrepreneurial when focused on improving nursing care to ensure quality, cost-effective outcomes. The opportunities presented by the current practice environment and defined system needs (IOM, 2004) can be clearly met by CNSs who have a strong foundation of clinical practice, specialty expertise, and a rigorous graduate education.

CNS Education in the Future

Becoming a CNS begins with educational preparation at the master's or doctoral level in a program that prepares CNSs to attain advanced specialty practice competencies. The NACNS *Statement on Clinical Nurse Specialist Practice and Education* (the Statement) (2004) has provided a consistent and solid platform upon which those competencies have been articulated

since 1998, with refinements made in 2004. The competencies and spheres of influence outlined in the statement have been validated and continue to resonate with CNSs in practice today (NACNS Competency Validation Survey, 2007).

Curricular Recommendations

The NACNS believes that the foundation of CNS practice encompasses the competencies attained through master's level education as articulated in the NACNS *Statement on Clinical Nurse Specialist Practice and Education* (2004). The core competencies as outlined in that statement (2004) may be revised in the future as the dialogue on the clinical practice doctorate continues to evolve. However, the core concepts of the competencies are enduring and must be maintained as the foundation of CNS practice regardless of changes in the degree attained (masters versus doctorate).

The following curricular recommendations are considered to be a minimum for the preparation of CNSs so that they can clearly be prepared for the future, yet maintain the strength of the long-standing solid foundation of the past preparation of CNSs. Some programs may decide to provide additional educational experiences. However, for a CNS to develop basic competencies, regardless of specialty, NACNS believes that the following will continue to be the core of CNS graduate preparation.

1. NACNS recommends the following core content specific to CNS practice (a description of each content area follows) (NACNS, 2004):

- Theoretical foundations for CNS practice

- Theory and empirical knowledge related to phenomena of concern that forms the basis for assessment, diagnosis, and treatment of illness and wellness within the CNS specialty
- Theoretical and scientific base for the design and development of innovative nursing interventions and programs of care
- Clinical inquiry/critical thinking using advanced knowledge
- Selection, use, and evaluation of technology/products/devices
- Theories of teaching, mentoring, and coaching for use in all three spheres of CNS practice
- Influencing change
- Systems thinking in regard to the organizational culture
- Leadership development for transprofessional collaboration
- Consultation theory
- Measurement
- Outcome evaluation methods
- Evidence-based practice and translation of research into practice

Essential Core Content Areas for Developing Clinical Nurse Specialist Competencies

A content area identifies the subject matter focus. Content areas do not specify courses since any content area may be represented by integrated threads throughout a CNS curriculum or be reflected in a discrete course. Content areas encompass all pertinent learning experiences in both

the acquisition and application of knowledge to CNS practice. The following areas of content are recommended for inclusion in CNS curricula as we look to the future:

1. Theoretical foundations for CNS practice: *Description.* This content area focuses on the theories and conceptual models, as well as the research that supports them, that shape the CNS perspective.

Examples include theories of health, illness, and wellness; health behavior (including self-care) and health behavior change; and theories of learning, stress, leadership, consultation, collaboration, patient safety, quality of care, cost of care, and organizational development.

2. Phenomena of concern: *Description.* This content focuses on theory and empirical knowledge related to specific illness and wellness phenomena. In order for the CNS student to engage in a differential diagnosis of illness and risk behaviors, knowledge of the causes of illness should be learned and applied to patient care within the context of disease as appropriate to the specialty. Phenomena from all three spheres of influence should be incorporated into the curriculum.

Examples of phenomena of concern might include symptoms and functional problems related to cognitive impairment, iatrogenesis, developmental delay, end of life/dying, environmental hazards, impaired mobility, ineffective coping, impaired wound healing, nausea, parenting, sleep disturbances, unsafe workplaces, and workplace violence.

3. Design and development of innovative nursing interventions: *Description.* This content area focuses on the design and development of nursing assessments, interventions, and programs

of care. The content includes validating existing practices and identifying the need for innovations. It also includes the theoretical and scientific basis for the selection and use of specific nursing assessment instruments and interventions and is the basis for nursing innovation.

Examples include creating innovative interventions to decrease medication errors, designing a program for parents of dying children, creating an innovative community-based screening and education program for patients/clients at high risk for chronic obstructive lung disease, and designing nursing assessments to identify factors related to risk for falls and developing innovative interventions to decrease risk.

4. Clinical inquiry/critical thinking using advanced knowledge: *Description.* This content area focuses on the development of intellectual skills that underpin the essential characteristics and competencies of the CNS. These cognitive skills are applied to the conduct of clinical inquiries to gain knowledge important for understanding the phenomena of concern to nursing, recognizing the nuances of patient experiences, and identifying commonalities and uniqueness across population groups. These skills are used to determine the appropriate application of evidence to individuals or to population groups. This content also includes the ability to reframe and hold biases and stereotypes in abeyance.

Examples of content include critical thinking, diagnostic reasoning, pattern identification, clinical decision-making, and problem-solving strategies.

5. Technology, products, and devices: *Description.* This content focuses on the critique, selection, and use of existing technology, products, and devices that support nursing practice and

contribute to improved outcomes. Content may also focus on the CNS's role in recommendations for the development of new technology, products, and devices.

Examples of content include critiquing patient education products; using informatics; evaluating technology, products, and devices from the perspectives of utility, cost-benefit analysis, ease of use, and effects on patient outcomes; effects on the nursing work, technology, and products to improve patient safety; and ethical considerations. In addition, content may include strategies for standardization of products across a system so that errors and variance are reduced.

6. Teaching and coaching: *Description.* This content area focuses on theories and research related to factors that influence learning, health behaviors, and the teaching and coaching of learners, who may be patients/clients, nurses, or other healthcare professionals.

Examples of content include conducting needs assessments; designing health messages and health education materials to match literacy ability, diverse cultural backgrounds, and physical capability; using theory to inform the design of teaching strategies to enhance learning environments; mentoring; and professional development strategies.

7. Influencing change: *Description.* This content area focuses on the underpinnings of the essential characteristics and competencies of the CNS. It includes change theory as well as techniques of persuasion, influence, and negotiation.

Examples of content include using persuasion to influence decision-making, building consensus through negotiation, using expert power, influencing changes in risk behaviors, and designing and implementing system-level change.

8. Systems thinking: *Description.* This content area focuses on system theory and research to understand, evaluate, and predict individual, group, and organizational behaviors. In addition, content focuses on the intended and unintended consequences of local changes on the system of care delivery. As an example, the incorporation of a new evidence-based assessment tool and its related staff education, changes in documentation requirements, and the organizational approval process may have an impact on more than the single unit in which the CNS provides service. The system-level effects of process changes must be evaluated and considered in the evaluation of care delivery. The content includes skills in participating in change and policy-setting to improve quality of care within a system, and most importantly, empowering the nursing staff in the care of the patients they serve. A professional nursing practice environment is one that empowers nurses to participate in clinical decision-making and organization of clinical care systems (AACN, 2002; Kramer & Schmalenberg, 2003).

Examples of content include assessing organizational culture, including formal and informal power bases; understanding how a change in one unit may create unintended adverse outcomes in another unit; engaging informal leaders in a planned change strategy; being able to constructively use system-level feedback to influence policies and standards of care; creating and evaluating organizational policy; and helping organizations respond proactively to outside influences requiring regulatory or other change. In addition, theories

of organizational behavior and change related to organizational learning and development should be included.

9. Leadership for transprofessional collaboration: *Description.* This content focuses on developing process leadership skills to create a collaborative environment for transprofessional teams. The content encompasses interpersonal qualities (e.g., respectful communication) needed to ensure a healthy work environment and shared goals in an organization.

Examples of content include developing facilitators and removing barriers to collaboration, working within the organizational culture, articulating the unique contributions of nursing within the context of transprofessional teams and describing the shared risks and benefits of collaboration, communicating with respect, risk-taking behaviors, and promoting the organization's vision.

10. Consultation theory: *Description.* This content area focuses on consultation theory and research and on the associated process skills of serving as a clinical expert consultant.

Examples of content include identifying a problem for which a consultant is appropriate, clarifying the role of a consultant in problem-solving, developing alternative strategies for a client/consultee to consider, revenue-generating processes, and using clinical expertise as a power base.

11. Measurement: *Description* This content area focuses on theories and clinical considerations of measurements (e.g., physiological, behavioral, psychosocial) required to assess and identify problems and to evaluate quality of care and clinical and fiscal outcomes.

Examples of content include selecting measurement instruments for evaluation of interventions at the individual, group, and system level and critiquing the validity, reliability, and clinical applicability of measurement instruments.

12. Outcome evaluation methods: *Description.* This content area focuses on research methods and techniques to evaluate nurse-sensitive outcomes consistent with the organization's mission and goals. These methods are also important for developing databases relevant to evaluation of CNS practice outcomes and efficacy of treatment at the patient level. Evaluation considerations might for example, relate to the various units of analysis within the system, the generation of cost-effective/cost-benefit data, and generation of data on patient outcomes such as symptom resolution, enhanced functional ability, patient and family knowledge, and patient satisfaction (Oermann & Floyd, 2002).

Examples of content include system characteristics, resources, and variance as well as the selection of appropriate outcomes of interest, including clinical and fiscal outcomes, patient/family satisfaction (Prevost, 2002), nurse satisfaction, and organizational outcomes such as recidivism, readmissions, and iatrogenic complications.

13. Evidence-based practice and translation of research: *Description:* This content area focuses on both critiquing and translating research for use in direct nursing practice.

Examples include sources of evidence and rating systems for levels of evidence, critiquing current practice in relation to its evidence base, applying evidence to designing innovations, skills to critique evidence-based research studies, skills to apply an evidence base to clinical practice, and sources of evidence-based guidelines.

14. Developing content areas: *Description:* There needs to be room for curricular innovation in relation to any role because societal needs change and demand for a specific content area may diminish as another arises.

Examples: "Placeholders" in a developmental area in the curriculum allow for changing societal needs and could include (but not be limited to) topics such as genetics/genomics, informatics, psycho-social, educational, and behavioral content to support patient/client self-determination, as well as productivity and billing information.

. The American Association of Colleges of Nursing (AACN) created a document in 1996 that outlined the core content required for all advanced practice nursing roles and required content areas for masters preparation. All the AACN-recommended graduate nursing core content (AACN, 1996) is recommended for CNS education. This includes content in these core areas: health policy, organization and financing of health care, research, health promotion and disease prevention, human diversity and social issues, ethics, professional role development, and theoretical foundations of nursing practice

In addition, the AACN-recommended content areas for advanced practice nursing core curricula (AACN, 1996) are important for CNS education, though additional emphasis in several areas is needed to meet the needs for future CNS practice. Each of the content areas listed below must be related to the CNS specialty in order to fully support the development of CNSs' ability to diagnose and treat illness, prevent illness, and alter risk behaviors (the *Statement*, 2004) in whatever specialty setting they are employed: advanced physiology/pathophysiology, advanced health/physical assessment, advanced pharmacology.

All CNS education provides a broad-based, in-depth knowledge of the specialty area. The NACNS supports the attainment of knowledge related to specialty nursing practice at an advanced level. The form that knowledge takes should be specific to the specialty. It is essential that CNSs have knowledge that supports provision of safe and effective care for the patient within the specialty focus. Further, the AACN *Master's Essentials* (1996) recommendations suggest that the CNS “should have a well-grounded understanding of basic pharmacologic principles, which includes the cellular response level” (p. 14). To that end, our recommendations for CNS education are to move beyond basic pharmacologic principles. Specifically, the following content is recommended: principles of pharmacodynamics, pharmacokinetics, pharmacotherapeutics, and drug-drug and drug-food interactions when appropriate to specialty. CNS practice focuses on differential diagnosis of illness such as symptoms and functional problems and risk behaviors. Additionally, CNSs are experts in executing selected delegated medical regimens associated with the diagnosis and treatment of disease for a specialty population. Therefore, they should also have educational content and practice components in the management of specialty populations.

NACNS defines prescribing more broadly than just pharmacologic interventions. Now and in the future, the CNS scope of practice must include the ability to prescribe interventions appropriate to the patient/client condition. This includes but is not limited to:

- referral and consultation to other health care professionals,
- ordering durable medical equipment,

- ordering diagnostic tests that will inform the plan of care, and
- ordering pharmacologic interventions when appropriate to specialty.

Prescriptive authority for pharmacologic interventions should be an option for all CNSs, but must not be a requirement for all CNS specialty practice. There are many CNS specialty practice areas in which the CNS will not need to prescribe pharmacologic agents for individual patients. When prescription of pharmacologic agents is needed by the CNS in order to ensure safe, cost-effective care that achieves positive patient outcomes, additional course content for pharmacologic prescriptive authority should include differential diagnosis and management of disease. Content for pharmacologic prescriptive authority should also include principles of selection of classes of drugs supported by an in-depth understanding of pharmacologic principles, information on state and federal statute related to prescribing, and information on fiscal and ethical implications of prescribing. In addition to the clinical practice hours needed to master the core CNS competencies recommended in the NACNS *Statement on Clinical Nurse Specialist Practice and Education* (2004), CNSs who prescribe pharmacologic interventions must demonstrate competence in the prescription of pharmacological agents through supervised clinical practice in the management of patients' pharmacologic needs. This will require additional clinical hours over and above those required for competence in the CNS role.

Additional Educational Preparation

In addition to the core content areas, the practice and socialization experiences of CNS students are shaped by the following:

1. Opportunities for students to develop competencies in the three spheres of influence through mentoring by CNS preceptors. Preceptorships provide continuing experiences with peer review and establish a network of CNS colleagues who can serve as resources for continuing development and professional collaboration. CNS students may augment clinical experiences by taking opportunities to work with other health care providers appropriate to the specialty. However, the emphasis of CNS student clinical experiences must be on learning the CNS practice competencies under the guidance of an experienced CNS who serves as preceptor.
2. Opportunities to individualize the program of study to meet personal career goals and competencies related to the CNS's specialty. Educational programs need to provide content on both CNS core competencies and specialty competencies if the education program purports to prepare students for practice in a specialty area. All CNS students are expected to receive a strong education foundation of advanced, general knowledge. Building upon this with specialty knowledge and experience prepares the CNS to better meet healthcare needs in the future.
3. Socialization experiences for full- and part-time students as a continuing process from the time of matriculation to graduation. The CNS educational preparation is more than the sum of completed courses. To become a clinical and professional leader, a CNS must integrate acquired knowledge and competencies with activities that enable the CNS to build a network with other specialty CNSs as well as with other nursing and policy leaders.

4. NACNS does not recommend “blended” or “merged” advanced practice educational programs – programs that purport to prepare students to obtain certification as both CNS and NP. Although some content may be applicable to both CNSs and NPs (e.g., theory, research, pathophysiology of disease), the application of content to meet the core competencies is different for CNSs and NPs. This statement is in no way intended to devalue our members who have been prepared as “blended” role specialists. It is instead recognition of the difficulty in keeping the two roles separate but contiguous and of the fact that the unique CNS role lends itself to clearly defined expectations of practice.
5. A minimum of 500 hours in clinical practice that includes practicum hours in each of the three spheres of influence is needed for students to acquire CNS competencies. Educational preparation as both a CNS and nurse practitioner (NP) within a single program means a student must complete supervised hours focused on the separate requirements for each of the CNS and NP practice competencies as recommended by NACNS and the National Organization of Nurse Practitioner Faculty (NONPF). This may mean as many as 1200 clinical hours for dually prepared individuals.
6. Direct entry or advanced entry masters or doctoral programs are becoming more common. Regardless of the program, it is imperative that the education prepares the future CNS to meet minimal competencies as defined by the NACNS *Statement on Clinical Nurse Specialist Practice and Education* (2004). It is the position of this organization that these competencies should build on the educational foundations of the Baccalaureate Essentials (AACN, 1996), a strong master’s-level educational program that

prepares CNSs, and clinical expertise that is developed over time. This expertise cannot be gained in limited numbers of clinical hours within an educational program. It is also recognized, however, that direct-entry students bring a wealth of personal and non-nursing professional experience with them. What continues to be of foremost importance is attainment of CNS practice competencies and an ability to demonstrate competency in the role. Educators must assess competency and validate that the future CNS has the appropriate knowledge, skills, and abilities to perform the role.

These recommendations for CNS education specify the preparation needed for the CNS student to develop the competencies necessary for future practice. The recommendations for curricula focus on essential content areas and threads, using recommendations of both AACN and NACNS. For preparation in a specialty area, schools of nursing may provide additional courses and experiences beyond these recommendations. Students' core preceptors should be CNSs who exemplify competencies and who can facilitate the students' socialization into the role. A minimum of 500 hours of direct clinical practice is necessary to achieve entry-level knowledge and competence in the three spheres of influence of CNS practice. More will be needed if pharmacologic management is included in the curriculum.

When looking to the future, questions that are currently arising in APRN discussions also are pertinent. NACNS believes that the master's degree is an appropriate level of education for entry into practice as a CNS. Although the knowledge and competencies needed for beginning CNS practice can be developed within the number of credit hours in a typical master's program, it does not preclude an entry into CNS practice at the doctoral level. However, specific

examination of the competencies required at a doctoral level of education for CNSs has not yet been completed, since traditional doctoral preparation usually has been focused on a research perspective. Discussions are underway at this time to clearly define the competencies that will define the preparation or enhancement of knowledge to be attained at the doctoral level. The future is open and the dialogue is strong.

Because the CNS serves as both the integrator of research into daily practice and the integrator of care across disciplines, additional education for the CNS could occur through any accepted doctoral degree option available in nursing. When considering enrollment in doctoral study, CNSs should identify doctoral programs that match their individual learning needs and career goals. It is expected that, over time, clarity will be gained in identifying additional competencies that can be attained by CNSs in furthering their education in either a research-focused PhD program in nursing or a non-research-focused nursing clinical doctorate.

The Purpose of Certification for CNSs

The third component of the NACNS vision relates to certification. To understand why certification is what it is today, it is important to recognize the past and acknowledge the current situation. The Committee for the Study of Credentialing (1979) identified certification as the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by an agency or association. Such qualifications may include a) graduation from an accredited or approved program, b) acceptable performance on a qualifying examination or series of examinations, and/or c) completion of a given amount of work experience. The purpose of certification is to ensure that an individual has mastered a body of knowledge and acquired

skills in a particular specialty.

Historically, CNS certification by professional nursing organizations represented attainment of excellence in practice. Taking a certification examination represented achievement of a level of expertise that was valued and recognized by peers and employers alike. In the 1990s, a shift occurred in the use of certification examinations when state regulatory agencies (state boards of nursing) began requiring a second license for Nurse Practitioners who extended into medical practice and moved beyond the legal scope of Registered Nursing practice. Certification exams previously designed to recognize excellence for those with a minimum of two years of experience were shifted to validation of entry-level knowledge for new graduates, thereby serving as a proxy for a licensure examination attesting to minimal competence to practice. However, certification by a professional nursing organization continues to serve important, if different, purposes including:

- verification of knowledge/competency for entry level practice,
- recognition of expert-level knowledge/competency, and
- validation of continuing competency.

Currently, regulatory requirements for CNS practice vary among states. The predominant trend is to require certification as a validation of attainment of initial advanced practice competencies and of recognition and authority to practice, much like the NP model. To that end, although philosophically counter to the belief that certification should continue to be a mark of excellence, NACNS recognizes the driving forces that affect its members and the need to continue to practice in states that require a certification examination as validation of attainment

of entry to advanced practice as a CNS. NACNS also recognizes that the purposes of certification presently are twofold:

- 1) to validate knowledge/competency for CNS entry into practice and
- 2) to meet emerging regulatory requirements.

Because CNS practice is based on changing needs identified in nursing practice and society as they arise, CNS specialties also change and evolve over time. This variability means that specialties arise more frequently and with smaller numbers of focused practitioners than would warrant certification examinations to be developed, validated, and maintained through legally defensible and psychometrically sound processes. As a result, several issues must be considered as CNS certification moves into the future:

- 1) Existing CNS certification exams need to reflect national CNS practice standards and core competencies. Just as the National Council Licensure Examination for Registered Nurses (NCLEX-RN) tests for RN core competencies, there should be a certification examination used as proxy for regulatory purposes for CNSs. Where specialty certification examinations exist, they should include testing of core competencies.
- 2) New certification mechanisms need to be developed for CNSs in specialty practice areas where certification exams do not exist and for practical reasons may never be created.

NACNS supports a certification model in which core CNS competencies are assessed in a format consistent with the core competencies outlined in the NACNS *Statement on Clinical Nurse Specialist Practice and Education* (2004) and in which the specialty competencies are also

assessed. This may mean a core examination in concert with a portfolio, simulation examination, or other means yet to be determined but that is legally defensible and psychometrically sound (Monsen, 2005).

3) The content of CNS certification examinations or legally defensible alternatives should be aligned with CNS educational programs. The NACNS *Statement* (2004) and this vision paper provide curricular and content guidelines that can and should provide the foundation of educational programs. These standardized expectations for the CNS provide an opportunity to align the content of CNS programs on a nation-wide basis. From the standardized content, a certification examination or legally defensible alternative can be structured. In order to accommodate all current specialty areas of CNS practice and to allow the flexibility of continuously developing specialty areas, NACNS supports a modular certification model that includes:

1. earned graduate degree in nursing that prepares the student for practice as a CNS,
2. exam module for validation of core CNS practice competencies, and
3. specialty module options to address specialty knowledge, which could include basic or advanced exams offered by specialty organizations, portfolios, or other potential psychometrically sound and legally defensible methods yet to be determined.

Guiding Principles of Certification:

NACNS supports the Accreditation Standards set forth by the American Board of Nursing Specialties (ABNS), which are based on the ANA criteria for definition of a specialty. Current

definitions are changing, however, and what used to be called a specialty is now more commonly being called a role. As such, the ABNS statements must be revised. However, NACNS continues to support the concepts in principle, with the term role in mind. Two of the ABNS standards are particularly relevant to the positions set forth in this paper:

Standard 1: Definition and Scope of Nursing Specialty [Role]

The certification examination program is based on a distinct and well-defined field of nursing practice that subscribes to the overall purpose and functions of nursing. The nursing specialty [Role] is distinct from other nursing specialties [roles] and is national in scope. There is an identified need for the specialty [role] and nurses who devote most of their practice to the specialty [role].

Standard 2: Research-based Body of Knowledge

A tested body of research/data-based knowledge related to the nursing specialty [role] exists. Mechanisms are established for the support, review, and dissemination of research in the specialty [role]. Activities within the specialty [role] contribute to the advancement of nursing science within the specialty [role].

Consistent with these two standards, NACNS supports the examination of CNSs that includes two essential elements: (a) measures of core competencies that distinguish CNSs as advanced practice nurses from the other groups of advanced practice nurses and (b) use of specialty science in assessment, diagnosis, and intervention with patients/clients served by the specialty.

The core competencies for all CNSs regardless of specialty have been developed and revised and have undergone extensive professional review; the most recent revision is published

in the NACNS *Statement on Clinical Nurse Specialist Practice and Education* (2004). These core competencies have been further validated through an assessment process with CNSs nationwide and the professional organizations by specialty (NACNS Competency Validation Survey Data, 2007). They have also been used as a framework for specialty competency development by the American Association of Critical Care Nurses and the Oncology Nursing Society, and they have been endorsed by the Emergency Nurses Association and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN).

The core competencies defined by NACNS (2004) provide a framework for a first-level assessment of core CNS competencies regardless of specialty. A second level of assessment would be defined by the specialty organization responsible for professional validation of that specialty. Assessment of the two essential elements may be done through written examination alone or a written examination on the core competencies with portfolio validation conducted by the specialty organization. NACNS is currently working with the American Nurses Credentialing Center (ANCC) Commission on Certification (COC) to develop a core CNS examination that will provide the foundation of recognition as a CNS through certification at a core level. Specialty knowledge will be demonstrated in partnership with the core examination through a portfolio evaluated by the specialty group in instances where there is no current examination available. The use of a core exam and a specialty portfolio for certification purposes will allow the creative development of new and emerging specialties when there may not be enough practitioners of the specialty to warrant and maintain a psychometrically sound and legally defensible written certification examination.

Much work remains to be done in this area, but the foundations have been built and continue to be developed and validated by stakeholder organizations. It is anticipated that in the future there will be a consistent core examination and additional specialty examinations when there is a large enough population to support the psychometric assessments on an ongoing basis. It is also expected that, when the population of CNSs seeking certification is too small to support psychometric assessments, there will be an alternative mechanism for validation of competency and certification.

The Future Regulation of Clinical Nurse Specialist (CNS) Practice

Since the process of regulation is now using certification as a quasi-regulatory mechanism, it is important to discuss the implications of the future regulation of CNSs. The draft NCSBN Vision Paper (2006) proposed recommendations to create uniformity and simplicity of regulatory requirements for Advanced Practice Registered Nursing (APRN). The draft (NCSBN, 2006) suggested that greater uniformity and simplicity of requirements would help to increase public and governmental understanding of advanced practice nursing, to protect the public, and to assist in the transferability of licensure across states. The NACNS agrees that there should be uniformity in the regulation of CNSs as advanced practice nurses. Congruency should exist between the educational preparation of CNSs, the CNS scope of practice, and the regulatory requirements for CNSs. However, the burden on the CNS in a specialty in which there is no certification exam, or in a state in which the CNS is not recognized as an advanced practice nurse simply for reasons of administrative ease for the board of nursing, is not in the best interests of the public and may be a restraint of trade.

Advanced Practice Registered Nurse (APRN) is the umbrella term used to denote the current four groups of advanced practice nurses: Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), Nurse Anesthetist (CRNA), and Nurse Midwife (CNM). The practice competencies of each group are distinguishable and unique. Regulation of practice, therefore, requires a uniform set of regulations for each individual group or category. Just as in certification of the unique roles, there is no one set of uniform regulations that will be applicable to all APRNs. One set of uniform regulations applied to all APRNs creates barriers for one or more of these groups, resulting in unnecessarily decreasing the public's access to quality care, economic harm to providers, and possibly restraint of trade issues. This section will outline the desired uniform regulations for Clinical Nurse Specialists.

The fundamental principle of regulation is to provide protection for the health, safety, and welfare of the public. Protection for the public regarding any profession includes:

- public understanding of who is qualified to practice within the professional role, and
- ensuring minimal competency in the professional role.

Clinical Nurse Specialist Regulation for Entry into Advanced Practice Registered Nursing

The vision for future regulation of CNSs as APRNs can be achieved through the following recommendations for public protection:

1. regulatory requirements to promote public understanding of titles and qualifications through the inclusion of title protection and scope of practice for CNSs in state statute and/or regulations, and

2. minimal competency for entry into practice as a CNS as defined by a regulatory requirement for the completion of a graduate degree (masters or doctorate) from a nationally accredited program that prepares CNSs.

An earned graduate degree in nursing from a nationally accredited program that prepares CNSs represents attainment of core knowledge of advanced practice nursing and knowledge specific to CNS practice. Clinical Nurse Specialist knowledge encompasses attainment of competencies in three spheres of influence: patient/client (direct care as clinical experts in the diagnosis and treatment of illness and the delivery of evidence-based nursing interventions); nurses/nursing practice (bridging the gap between what is known and what is done in practice); and the organization/system (contributing to system improvements that facilitate the practice of nursing). Clinical Nurse Specialist practice competencies prepare the CNS to advance the practice of nursing as it applies to any delimited area of practice or specialty (NACNS, 2004). An earned graduate degree serves as the broad-based educational preparation required to meet the advanced *nursing* needs of the public across the lifespan, populations, and settings.

In the future, the CNS will continue to practice nursing at an advanced level as an advanced practice nurse. Having the competencies for advanced nursing practice is prerequisite to the contributions CNSs will make to high quality patient/client care outcomes. Although the scope of practice for a CNS will continue to extend beyond the scope identified for Registered Nurses and is advanced practice nursing, CNSs will not duplicate the work of NPs, Nurse Midwives, or Nurse Anesthetists. The CNS functions at an advanced level of practice and requires the protection of a defined scope of practice and title protection within regulatory

language. Depending on the state or territory in which the CNS practices, this may mean an additional certification or validation by the state that they are both an APRN and a CNS.

If a CNS's practice extends into the treatment of disease through pharmacologic management, it is clearly appropriate to create additional regulatory requirements that will take protection of the public into consideration. The NACNS has disseminated two position statements on advanced pharmacology practice, curriculum, and regulatory recommendations (NACNS, 2003, 2005a) that clarify the recommendations for advanced pharmacology knowledge, education, and regulation for CNSs as described in the NACNS *Statement on Clinical Nurse Specialist Practice and Education* (2004). These documents explain that CNSs who wish to utilize pharmacologic means to manage their individual patient population should meet the same regulatory requirements of any APRN with prescriptive authority as required by their individual state.

Regulation at the specialty level will always be problematic because these specialties evolve as societal needs and the science of care advance. For that reason, we believe that CNSs should be regulated at the role level. The level of regulation required to meet the two criteria for public protection can be accomplished through title protection, scope of practice, and registration. The NACNS has developed model regulatory language for use by individual states in drafting their nursing practice regulations (NACNS, 2005b) that clearly protects the title and public access to the services of a CNS without undue burdensome regulation.

Clinical Nurse Specialists will be recognized as APRNs well into the future. The public will continue to have access to the advanced nursing care that CNSs provide, whether that care is

delivered to individuals, families, groups, or communities/populations. Title protection and a defined and unique scope of practice are essential to ensure the public's protection and access to the specialized advanced nursing care CNSs provide.

Summary

The CNS role clearly continues to have broad application within multiple healthcare settings. As the Institute of Medicine (1999, 2004) identified, there is a need for a professional in health care that can integrate the systems of care and ensure patient safety. The CNS is uniquely prepared to be the transprofessional collaborator, change agent, EBP integrator, and patient/client outcomes driver who will ensure safety and quality outcomes for patients now and into the future. CNSs can only do that through recognition of their practice, acknowledgement of the educational standards they must meet, certification as a mark of excellence, and most importantly, through title protection and a defined and unique scope of practice that ensures public access to appropriately trained and qualified CNSs. The future is bright for the CNS as their role is increasingly recognized and valued, and their goal of optimal patient/client outcomes in all settings is an imperative that will guide the CNS well into the future.

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