Document A for Comment

3rd Edition

Statement on Clinical Nurse Specialist Practice and Education

National Association of Clinical Nurse Specialists

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NACNS recognizes the authors of the third edition of the NACNS *Statement on Clinical Nurse Specialist Practice and Education.*

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INTRODUCTION

Clinical Nurse Specialists (CNSs) comprise a group of over 70,000 advanced practice registered nurses (APRN) (NACNS, 2017). In 1995, the National Association of Clinical Nurse Specialists (NACNS) was formed to be the national organization specifically dedicated to CNS issues and to promote the unique practice of CNSs. Since that time, NACNS has been a leader in articulating CNS practice competencies, educational guidelines, and credentialing requirements. The competencies and expected outcomes that distinguish CNS practice are articulated in this 2018 revision of the NACNS Statement on Clinical Nurse Specialist Practice and Education.

The NACNS Statement is an evolving document and will continue to be shaped over time; however, it will always reflect NACNS's commitment to ensuring that society benefits from the full range of nursing services and the competencies characteristic of CNS practice. A national consensus on CNS competencies and outcomes brings CNS contributions to the forefront and shapes the agenda for education, public policy, professional practice, and performance standards.

Section 1 of the updated Statement defines the CNS and describes CNS practice, in light of the significant changes in today's healthcare environment. It provides a conceptual model of CNS practice, and describes the social mandate for CNS practice; the relationship between CNS practice, specialty knowledge, and practice standards; as well as the regulation and validation of CNS practice. Sections 2 and 3 focus on the competencies and outcomes of CNS practice across the three spheres of impact. Section 4 explains the recommendations for graduate preparation of CNSs to achieve the core competencies described in Section 2. Appendix A is a glossary of terms used throughout the document.

Parameters of the Statement

Clinical expertise in a specialty is the hallmark of CNS practice. For the CNS, entry into practice occurs at the level of the Master's or Doctor of Nursing Practice (DNP) degrees. This Statement describes core baseline competencies for CNS practice regardless of specialty and level of preparation. Mastery of the competencies is achieved with experience and continuing education.

The conceptual model utilized to describe the competencies of a CNS uses three spheres of impact as the framework. CNS practice includes the patient sphere, the nurses/nursing practice

sphere, and the organization/system sphere. NACNS recognizes that, depending on specialty, settings, populations, and other factors, actualization of individual CNS practice may vary. This document describes the competencies for the entire framework of CNS practice with the emphasis that the primary focus of any CNS's purpose for practice is to improve and optimize the care of the individual patient/family.

The competencies required for specific CNS specialty practice are not addressed in this document. Individual CNSs are expected to define their practice using this Statement along with other relevant specialty standards from specialty organizations. By defining core competencies, this Statement has implications for credentialing, education, and regulation. It articulates the unique competencies of CNS practice and the education necessary to support that practice. This Statement does not compare CNS practice with the practice of other advanced practice nursing groups.

Goals of the Statement

The purpose of the NACNS Statement on Clinical Nurse Specialist Practice and Education is to describe entry-level competencies and associated outcomes for CNS practice regardless of specialty across three spheres of impact. Specialty competencies, including those associated with populations or settings, should overlay the entry-level competencies to provide greater specification or emphasis among the competencies across the three spheres.

The Statement has three goals. The goals are to:

- Make explicit the contributions of CNSs in meeting societal healthcare needs;
- Articulate core competencies for CNS practice and associated outcomes;
- Provide a standardized framework for CNS education at the graduate level.

SECTION 1.

CLINICAL NURSE SPECIALIST PRACTICE

Introduction

Clinical Nurse Specialists are one of four categories of advanced practice nurses, each with distinctively different practice characteristics. While all four groups—clinical nurse specialists, certified nurse practitioners (CNP), certified nurse midwives (CNMs), and certified registered nurse anesthetists (CRNA)—have their origins within professional and statutory definitions of nursing, each group's practice has expanded and evolved in diverse ways beyond required APRN core competencies to meet different aspects of the health needs of individuals, families, populations, and communities. Each category of advanced practice nursing has a knowledge

base unique to its practice to support its distinctive contributions. Each group's unique practice functions within the healthcare system for the purpose of delivering cost-effective quality outcomes.

The essence of CNS practice is advanced clinical nursing expertise in diagnosis and intervention to prevent, remediate, or alleviate illness and promote health with a defined specialty population—be that specialty broad or narrow, well established, or emerging. The totality of CNS expert clinical practice is manifested in the advanced care of patients (I.e. individuals and families) and impacts populations and communities. The knowledge the CNS gains in direct practice with patients and families is frequently used to make improvements in entire patient populations, though the focus of CNS care is at the patient/family level. CNS practice is the translation of clinical expertise into nursing care provided directly and by influencing nurses and nursing personnel through evidence-based practice. CNS practice also transforms systems (i.e. healthcare institutions and systems, political systems, and public and professional organizations) to mobilize and change these systems through expertly designed and implemented nursing interventions. CNSs are uniquely qualified to improve healthcare in the achievement of all 6 aims of the Institute of Medicine (IOM) report: having healthcare that is safe, effective, patient-centered, timely, efficient, and equitable (IOM, 2001). Thus, CNS practice is consistently directed toward achieving quality, cost-effective patient-focused outcomes across all three spheres of impact. Illness may occur whether or not a patient has a disease (see the Glossary for the definitions of illness and patient). CNSs who care for patients experiencing illness with disease etiologies are also experts in assisting with disease-related diagnoses and interventions.

Social and Professional Mandate for CNS Practice

The role of the CNS was created to meet the increasingly complex needs of patients. This need has not abated and in fact, becomes even more of a priority within the context of the ever-increasing complexity of healthcare itself. 'Patient' in the context of this statement encompasses the broadest sense of the word—individuals, families as defined by the patient, patient populations, communities, and in some cases, may even include healthcare surrogates. Patients today are increasingly complex with potential or actual multiple chronic conditions, psychosocial, and socioeconomic challenges who are trying to navigate a frequently changing healthcare environment. In addition, patients demonstrate increasing diversity and identify with ever-varied cultural backgrounds. This increase in diversity and cultural backgrounds necessitates that CNSs approach each individual patient and family as unique and distinct, without assumptions of any broad brush of cultural or diversity categorization. Through a relationship-centered care foundation, CNSs provide expert care to patients with complex conditions. The relationship with the patient/family is of primary importance, while recognizing

that additional relationships such as those with other care providers and the community, support a comprehensive approach to optimizing health through reciprocal influences. CNSs advance the practice of nursing for these patients by (a) designing innovative evidence-based interventions, (b) setting practice standards and influencing the practice of other nurses, and (c) leading within the healthcare system environment to improve patient care and support quality outcomes.

As a profession, nursing has a social mandate to evolve its practice to meet the needs of the society, which creates and supports it. The profession is responsible for helping shape statutes and regulations that impact the health of patients and families. Professions are responsible for self-interpretation and self-regulation; therefore, it is imperative that nursing continues to critically self-appraise in the context of contemporary social needs. Regulatory agencies are mandating that healthcare institutions demonstrate quality outcomes in order to receive reimbursement for care provided. Patients are increasingly aware of the outcomes of individual providers and healthcare institutions, demanding care that is safe, high quality, individualized, and cost effective. This expected evolution and the increasing complexity of care is part of the rationale behind the emphasis on the DNP degree for all advanced practice registered nurses, including CNSs, which aims to prepare nurses at the highest level of practice in order to provide advanced care within this context (American Association of Colleges of Nursing [ACCN], 2006). Because CNSs demonstrate mastery in the translation of evidence into nursing practice, CNS leadership in advancing nursing practice as a profession is critically important.

The American Nurses Association (ANA) recognizes CNSs as advanced clinical experts in nursing with attributes distinguishing them from other APRNs with the primary role of the CNS to continually improve the nursing care of patients resulting in improved patient outcomes (ANA, 2010). The ANA acknowledges that while there is an overlap of knowledge and skills among the advanced practice groups, the scope of practice of CNSs is distinguishable from the other advance practice nursing groups. CNSs bring analysis and implementation of emerging nursing science and evidence to the range of care in the wellness-illness continuum including: facilitating maintenance of health, prevention and early detection of illness; diagnosis and treatment of acute illness; management of chronic illness; and optimization of transitions of care.

CNSs integrate scientific evidence to design new interventions that treat symptoms, functional problems, and complications of disease treatment. Regardless of the setting, complications and failure to recover from disease and medical treatment may be prevented by appropriate diagnosis and treatment of illness. CNSs are skilled at advanced individual patient assessment and development of a treatment plan, but also use their assessment skills to identify overall

trends and patterns, utilizing the information to lead quality improvement changes for patients and patient populations. Innovation in illness diagnosis and treatment is one of the hallmarks of CNS practice. CNSs have in-depth advanced knowledge of evidence-based nursing practice within a specialty that results in competencies to (a) expand the boundaries of nursing practice by focusing on illness management, (b) advance the practice of other nurses and nursing personnel, and (c) develop organizational/system modifications to support and improve both patient outcomes and the practice of nursing.

Definition of Clinical Nurse Specialists

In 2008, a joint group of the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee issued a statement that was a sentinel point in defining the role and preparation of APRNs: The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education (APRN Joint Dialogue Group, 2008). This document identifies the four APRN roles (CNS, CNP, CRNA, and CNM) and outlines the core elements that are minimal requirements in order to be considered an APRN. It is imperative for all nurses and nursing leaders to understand these core elements in order to accurately appreciate who is prepared to function as an APRN and who is not–particularly in light of confusion related to the increasing numbers of nurses prepared at the DNP level. The DNP is a degree, not a role. This document provides the foundation for defining any one of the APRN roles including CNSs.

- The core criteria required to be considered an APRN are:Education in one of the four identified APRN roles
- Education in at least one of six identified population foci (family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related, psych/mental health)
- Education that includes the 3 p's: advanced physiology/pathophysiology, advanced health/physical assessment, advanced pharmacology
- Certification in at least one of the roles and at least one of the population foci through a national accredited program
- Licensed at the APRN level in at least one of the roles and at least one of the population foci (Consensus Model, 2008)

In alignment with the Consensus Model criteria, CNSs are licensed registered professional nurses with graduate preparation (earned Master's or doctorate) from an accredited program that prepares CNSs. They may also be prepared in a post-master's certificate program that is recognized by a national nursing accrediting body as preparing graduates to practice as a CNS.

CNSs are advanced clinical experts in the diagnosis and treatment of illness, and the delivery of evidence-based nursing interventions (AACN, 2006). They possess advanced knowledge of the science of nursing with a specialty focus and apply that knowledge to nursing assessments, diagnoses, interventions, and evaluation, and the design of innovations. They function independently to provide theory and evidence-based care to patients in their attainment of health goals.

CNSs are unique from the other APRN roles as they also have a significant focus of the role on areas outside the direct patient interface. CNSs practice from both an expanded and specialized area of expertise. From an expanded nursing practice perspective, CNSs are skilled at systems thinking in order to enhance patient care by identifying gaps, forging and leading collaborative relationships, leading quality improvement efforts, and creating innovative workflows. They work with other nurses to advance their nursing practices and improve outcomes, and provide clinical expertise to affect health system-wide changes to improve programs of care. In addition, CNSs are particularly prepared to care for complex and vulnerable patient populations. For example, as a result of their expertise in advanced direct patient care, CNSs are in an ideal position to create and implement delivery models to lessen the risks that can occur with transitions of complex patients between multiple specialty and primary care providers and between healthcare settings and home.

Many of the expert skills CNSs are prepared for and expected to exhibit (e.g., leadership, collaboration, consultation, quality improvement and evidence-based practice, systems thinking, professionalism, and ethical conduct) are also exhibited by other nurses and nursing leaders. CNSs, however, are unique in that they are also prepared in advanced patient care in a specialty. Therefore, CNSs consistently utilize those expert skills within a framework of an advanced direct patient care perspective. This distinctive combination is what distinguishes CNS practice from that of nurse executives, quality improvement specialists, nurses with a DNP in leadership, or an experienced staff nurse, for example.

Conversely, while CNSs must be prepared in one of the six population foci (a core foundation of the role), they also specialize in a delimited area of practice with evidence-based competencies associated with that specialty. APRN specialties are defined as “a focus of practice beyond role and population focus linked to healthcare needs (examples include but are not limited to oncology, older adults, orthopedics, nephrology, palliative care) (APRN Joint Dialogue Group, 2008).

Specialty areas are evolving as the science of care evolves. Typically, the specialty can be identified in terms of the population being cared for, type of patient problem, setting, type of care, and/or disease or medical specialty. Specialties usually address more than a single population, may or may not have an advanced practice certification available, and can be

identified by a national organization or a single entity (e.g. clinic, hospital grouping). Table 1 highlights examples of specialties that exist in relation to the overarching populations as defined by the Consensus Model (2008).

Table 1.

Population					
Family/Individual Across Lifespan	Adult-Gerontology	Neonatal	Pediatrics	Women's Health/Gender-related	Psychiatric-Mental Health
Specialty Examples with CNS Certifications (may cross populations)					
Adult Health CNS Adult-Gerontology CNS Adult Psychiatric-Mental Health CNS (CNS exam retired in 2015) Advanced Oncology CNS Child/Adolescent Psychiatric-Mental Health CNS CNS Perioperative CNS Wellness through Acute Care (Adult-Gero) CNS Wellness through Acute Care (Neonatal) CNS Wellness through Acute Care (Pediatric) Diabetes Management-Advanced Gerontological CNS Home Health CNS Orthopaedic CNS Pediatric CNS					

While many registered nurses and nursing leaders may have skill and expertise in some of the competencies outlined in Section 2 of this statement, either through formal education or clinical experience, it is an expectation that CNSs are uniquely prepared through higher education to function at this advanced level of nursing practice in all competencies outlined in this document.

Relationships between CNS Practice, Specialty Knowledge, and Practice Standards

This Statement describes the core CNS practice competencies in three spheres of impact. The core competencies are consistent across all specialty practice areas, and are actualized in specialty practice (see Figure 1). The essence of CNS practice is advanced clinical expertise based on advanced knowledge of nursing science. Thus, the patient sphere is depicted as the largest and most all-encompassing. CNS clinical expertise, directed by the specialty, is the basis

for competencies in the nurses/nursing practice sphere and the organization/system sphere. The context for CNS practice is the specialty. The specialty directs specific knowledge and skill acquisition; thus, the specialty area competencies build upon the core CNS competencies in an in-depth area of clinical expertise.

Because CNSs are prepared at an advanced level in all 3 spheres, activities in one sphere interact with, impact, and enhance activities in the other spheres. Optimal results are achieved when CNS knowledge and function in each sphere synergistically augments the overall outcome. The full impact of the role is exhibited when the CNS functions in all 3 spheres over the balance of the role. The unique nature of this APRN role is the ability to be flexible and evolutionary in meeting the healthcare needs of patients in all 3 spheres. The work therefore also fluctuates at any given time, depending on the needs of the organization, unit, or patient(s). While the spheres intersect and overlap, the direct care sphere is the all-encompassing, overarching focus of the CNS role.

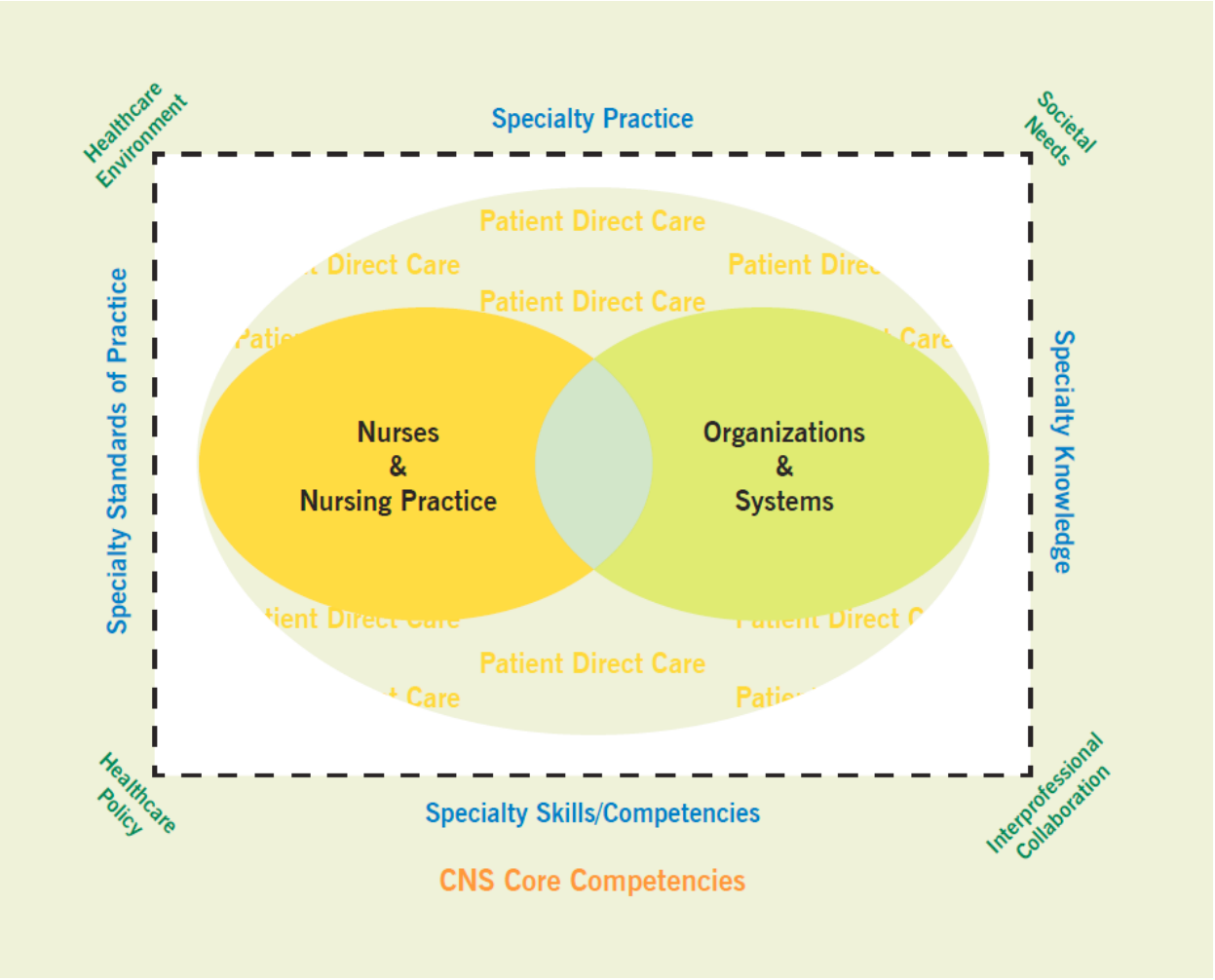

Figure 1. CNS practice conceptualized as the core competencies in three interacting spheres actualized in specialty practice, and guided by specialty knowledge, skills/competencies, and standards of practice within the context of the ever-changing healthcare environment, healthcare policy, interprofessional collaboration, and societal needs. The core is the foundation upon which to build specialty competencies.

Conceptual Model of CNS Practice

Historically, the broad scope of CNS practice was described in terms of sub-roles, including expert clinician, educator, researcher, change agent, administrator, and consultant (ANA Council, 1986; Hamric, 1989; Sparacino, 2000). These sub-roles were created at a time when schools of nursing were seeking ways to organize concepts and activities to direct curricula. However, defining CNS practice by sub-roles partitions the skills and activities rather than integrating them. It is the integration and aggregation of those activities that makes for effective CNS practice. The CNS role reflects all of these sub-roles and is fluid from moment-to-moment.

While CNS advanced competencies are integrated across the three spheres of impact ([1] patient direct care, [2] nurses/nursing practice, [3] organization/system), expert nursing practice in the patient sphere provides the underpinnings for advanced practice. Thus, the model for CNS practice, as articulated in this and the original Statement (NACNS, 2004) is based upon the position that CNS practice is consistently targeted toward achieving quality, evidence-based, and cost-effective outcomes through advanced, specialized patient care. In addition, the CNS also influences the practice of other nurses and healthcare personnel, as well as the healthcare organization/system, to support nursing practice through advanced specialty clinical expertise, advocacy, consultation, collaboration, scholarship, and leadership. CNSs are effective advocates due to their advanced knowledge and expertise in all three spheres of impact. The CNS serves as a consultant for complex patient problems; staff knowledge, and performance assessment and enhancement; program development; professional practice and best-practice model development and implementation; system change strategies; and professional development. As a content expert, the CNS suggests a wide range of alternative and innovative approaches to clinical or systems problems.

Elements of the model are interactive and collectively determine the scope or breadth of practice activities within and across the spheres. The core competencies for each sphere of impact and associated outcomes are presented in Section 2.

CNS PRACTICE: PATIENT DIRECT CARE SPHERE

CNSs have advanced knowledge and skills to assess, diagnose, and treat illness. The CNS performs evidence-based assessment and treatment of illness including symptoms, functional

problems, and risk behaviors. The CNS is educated and skilled in comprehensive assessment, differential diagnosis, and interventions to prevent or treat illness. CNSs use advanced communication skills in complex situations and conversations that may be unpredictable while caring for patients throughout the health continuum. Patients may seek or need the care of the CNS to prevent, alleviate, or minimize illness, or to alter risk behaviors. The CNS may intervene to educate, guide and coach the patient in modifying risk behaviors, and emphasize health-promoting lifestyles. The CNS leads discovery of innovations in patient care using nursing science, theory, and knowledge generated by nursing and related disciplines.

CNS PRACTICE: NURSES AND NURSING PRACTICE SPHERE

The CNS advances nursing practice and improves patient outcomes by assuring nurses and nursing personnel utilize evidence-based practices to support patients and families during acute care and in transitions from acute care settings to home and community environments. The CNS develops population profiles and conducts clinical inquiries to determine the need to change practice. The CNS exerts influence through role modeling, consultation, and education with other nurses and healthcare providers to improve nursing practice and thus improve patient outcomes. The CNS is a skilled communicator and educator with expertise in listening, validating, reflecting, providing constructive feedback, and supporting the nurse and nursing team. The CNS creates and develops evidence-based policies, procedures, and protocols, and best practice models/guidelines using advanced knowledge of specialty clinical population. The CNS assists nurses and the interprofessional team to evaluate and change practice standards and ensure that nursing practice is evidence-based.

CNS PRACTICE: ORGANIZATION/SYSTEM SPHERE

The third sphere of CNS impact—the organization and system level—is critically important due to the complexity of healthcare. The CNS articulates the value of nursing care at the organizational or decision-making level, and advocates for professional nursing. The CNS influences the trajectory of care from admission through discharge to home in order to assist the patient in achieving their desired outcomes after discharge and minimize recidivism and readmission. Because of advanced assessment, diagnostic, and collaboration skills coupled with advanced knowledge of systems, safety, and quality, CNSs facilitate transition of care across settings. To enhance abilities of patients and their families to manage care at home, the CNS leads nursing and interprofessional groups to implement innovative patient-centered care programs that address patient needs across the full continuum of care.

The CNS leads systematic quality improvement and safety initiatives based on gap assessments and data analysis to improve nursing practice for safe, high quality, and cost-effective patient outcomes. The CNS drives translation of best evidence into practice and facilitates integration

of multiple programs and disciplines across the healthcare system to assure positive patient outcomes. The CNS collects and analyzes patient data to document the impact of nursing practice on outcomes, efficiency, and cost-effectiveness. The CNS has expertise in using collaborative systems thinking to determine what is working well, and what requires intervention to best predict and achieve quality cost-effective patient care and outcomes. The CNS interacts with governmental and regulatory agencies, healthcare insurers, and consumers to assure access to healthcare services and safe competent nursing care. In addition, CNSs use their expert leadership skills individually and through their professional organizations to influence policy makers and advocate for equitable health care.

Legislative Regulation of Clinical Nurse Specialist Practice

CNSs are licensed registered professional nurses who are educated at the graduate level as CNSs to practice nursing at an advanced level. Regulation of CNS practice includes both title protection explicated in statute and scope of practice delineated in regulations.

Statute/Law: Title protection for CNSs should be included in state statutes (laws created by legislative bodies). A statute granting title protection should specify that those who use the CNS title must hold a graduate degree (masters or doctorate) in nursing from a program that prepares CNSs. Lack of title protection in a state can result in misuse of the title by those without graduate preparation as a CNS and can be misleading to the public.

Regulation: The scope of CNS practice should be explicated in regulation. The scope of practice should be such that CNSs are recognized and held accountable for nursing at an advanced level. Evidence of specialty expertise may be defined in regulation. Requirements for evidence such as psychometric examination, portfolio, continuing education, or other mechanisms, if required, should be obtained from professional specialty organizations, and should be available, legally defensible, and logically linked to the specialty practice.

The registered nurse license authorizes autonomy in the diagnosis and treatment of health-related problems amenable to nursing interventions, as well as the authority to execute medical regimens. CNS education prepares graduates to expand the practice of nursing through application of knowledge and development of competencies for the purpose of increasing the depth and breadth of nursing practice within nursing's autonomous scope. CNSs are also responsible for the delivery of medical therapies as they apply knowledge and develop skills related to the methods, techniques, and management of medical therapies.

Professional Validation of CNS Competencies

Validation of practice competency and practice expertise is the responsibility of professional organizations. Validation should be consistent with the specialty focus of the professional

organization. NACNS supports a wide variety of initiatives by professional organizations to validate practice competencies of CNSs. Professional validation of practice competencies must include the core competencies for CNS practice as actualized in specialty practice. NACNS supports various methods for validation of competencies. Validation of competencies may occur at various time points in a CNS's career, including entry into practice and continuing abilities. Evidence used for validation of continuing competencies may include continuing education, psychometric examination, portfolio review, publication, research activities, or other evidence or combinations of evidence determined appropriate for the specialty by the professional organization.

Validation of competencies should match the specialty focus of the CNS practice. Validation of broad competencies or competencies in related content or practice areas do not attest to specialty competency.

Summary

Nightingale's (1859/1969) groundbreaking work on the nature of nursing as separate from medicine set in motion the rich history of nursing as a profession with an autonomous practice. Peplau's (1965/2003) delineation of CNSs as master's prepared clinical nursing experts provided the underpinnings of a specialized group of advanced practice nurses. Fulfilling a professional and societal mandate, CNSs use evidence to change nursing practice to improve clinical and economic outcomes across three spheres of impact. CNSs advance nursing practice by serving as advanced expert clinicians, prepared at the graduate level, who assure that nursing interventions are based upon the best available evidence. CNSs integrate nursing practice with medical practice when patient problems are due to both illness and disease-related etiologies. CNSs translate new knowledge into innovative practice, identify clinical phenomena that need empirical examination, and support intervention research that brings new nursing therapies to practice. CNSs work collaboratively with nurses and other providers of healthcare to achieve high quality, cost-effective outcomes for individuals and populations. CNSs are responsible for advancing and articulating the unique contributions of nursing care in an interprofessional healthcare system to patients, nursing personnel, and organizations as well as to the public and policy makers.

SECTION 2.

CLINICAL NURSE SPECIALIST CORE COMPETENCIES

Introduction

The core CNS competencies represent the foundation of clinical nurse specialist practice today in a complex and evolving healthcare system. The core CNS competencies are comprehensive,

entry-level competencies and behaviors expected of graduates of all programs that prepare CNSs. Due to the wide range of specialties in which CNSs practice, these competencies reflect CNS practice across all specialties, populations, and settings. Fundamental to these competencies is that the CNS maintains clinical privileges including state licensure and/or designation as an advanced practiced registered nurse, certification as a CNS in one of the six approved population foci, and has completed a course of education as a CNS by an accredited program. (National CNS Core Competency Project Executive Summary, 2008; APRN Consensus Model)

Domains of the Core Competencies

The core competencies presented in this statement align with the domains or categories utilized in the preparation of the 2010 Clinical Nurse Specialist Core Competencies (NACNS, 2010) and the domains utilized in the 2017 Common APRN Doctoral-Level Competencies and Progression Indicators (AACN, 2017). The latter adopted the Common Taxonomy for Competency Domains in the Health Professions (Englander, R., Cameron, T. et al. 2013) For example, within the Patient/Direct Care Sphere of Impact, the first competency is: Uses relationship-centered communication to promote health, healing, self-care, comfort, and peaceful end-of-life. This aligns with Direct Care from the 2010 document and with the Domain of Interpersonal and Communication Skills in correlation with the Common APRN Doctoral-Level Competencies. This crosswalk was conducted to ensure the competencies are reflective of relevant domains utilized in the past and contemporary domains that promote interprofessional practice.

Conceptual Framework: Core Competencies by Spheres of Impact

The three spheres of CNS impact provide an organizing framework to describe core CNS competencies. These competencies represent essential skills used to achieve desired outcomes in CNS practice. A CNS may focus on any one or all of the three spheres of CNS practice, but clinical expertise in the patient and direct care sphere remains the core of CNS practice for each of the other two spheres. These competencies are used in other spheres to influence nurses, nursing practice, and the organizations and systems to improve patient outcomes, provide cost-effective care, and advance nursing practice. Deliberative CNS practice, working with colleagues from other disciplines, assures that desired patient/client outcomes will be attained.

Insert Core Clinical Nurse Specialist Competencies

SECTION 3.

OUTCOMES OF CLINICAL NURSE SPECIALISTS

Introduction

The outcomes of clinical nurse specialists' practice were first published in the 2004 statement (NACNS, 2004). The extensive annotated bibliography of research studies and articles about CNS practice and outcomes by Kathleen Baldwin, PhD, RN, and NACNS, has been archived with NACNS. In 2015, a descriptive study was conducted by Fulton et al to assess CNSs' perceptions of the ongoing validity of outcomes published by the National Association of Clinical Nurse Specialists. (Fulton, J. et al., 2015). The findings of the study demonstrated agreement with identified outcomes and current CNS practice.

Conceptual Framework: Outcomes of Clinical Nurse Specialists by Spheres of Impact

The validated outcomes of clinical nurse specialist practice have been cross-walked with the core competencies. Each competency within each sphere does have an associated outcome. This provides for confidence in the relevance and importance of the individual competencies within the framework of the spheres of impact.

Insert Outcomes of Clinical Nurse Specialists

SECTION 4.

Introduction

This section presents recommendations for graduate preparation of CNSs necessary for the acquisition of CNS core competencies. The curricular content areas were derived from a review of the literature, feedback from practicing CNSs, and review of education standards (AACN, 2006; AACN 2011). It is important to note that curriculum for specialty practice competencies is beyond the scope of these recommendations. For specialty practice, national standards articulated by specialty organizations should be used to develop additional courses, content areas, or threads as needed. The recommendations contained in this section are designed to provide guidance to CNS educators as they evaluate, revise, or develop CNS programs. They may also be used to guide current CNSs in practice as they continue their professional development.

History and Evolution of CNS Education

In direct response to the National League for Nursing's recommendations for universities to develop master's level nursing curricula, Peplau and Reiter proposed the psychiatric CNS role in the 1940s as a model of advanced clinical nursing (Fulton, 2014; Reiter, 1966). The first CNS program was initiated at Rutgers University in 1954, heralding a fundamental shift in education for nurses away from the culture of hospital-based diploma education to university-based education leading to specialty practice knowledgethrough the integration of theory and science

(Fulton, 2014; Mick & Ackerman, 2002). CNS education was developed to prepare CNSs as expert clinical nurses, providing specialized nursing care directly to patients, and indirectly improving care by focusing on nursing staff education and system analysis (Boyd, 1991; Fenton, 1985; Page & Arena, 1994).

By 1980, there were multiple programs for CNS education, and early evaluation research validated the innovative contributions of CNS care (Bigbee & Amidi-Nouri, 2000; Georgopoulous & Christman, 1970; Georgopoulos & Jackson, 1970). During the 1980s, some nursing leaders suggested that reconfiguring the curricula and coalescing the CNS, NP, and CNM roles into one single advanced practice nursing role was a way to gain political clout and position nurses as a major provider of primary care, gaining public acceptance of APNs (Schroer, 1991). The proposal for a single title, however, generated significant debate within the profession (Sparacino, 2000) and was abandoned because the unique contributions of each group were lost.

During the 1990s, variability in CNS education requirements existed across the country (Fulton, 2014; Walker et al., 2003). Surveys of graduate nursing programs that prepared CNSs, NPs, and CNMs in the United States revealed significant variations in the length of programs, number of courses in the major, specialty titling, and competencies (American Association of Colleges of Nursing [AACN], 1994; Burns et al., 1993; Walker et al., 2003). These findings, along with changes in the healthcare system and debate within the nursing community concerning the requisite knowledge for nursing at the advanced level led to the publication of several position statements. These statements provided direction for advanced preparation by (1) recommending changes in the regulation of health professionals (Pew Health Professions Commission, 1995), (2) delineating the scope and standards of advanced practice nursing (ANA, 1996; ANA 2004), and (3) providing guidelines for graduate preparation of advanced practice nurses (AACN, 1996).

The AACN's The Essentials of Master's Education for Advanced Practice Nursing (1996) filled a gap by offering guidance for curricular development for graduate programs. This document stated that graduates of master's programs in nursing must have "critical thinking and decision making skills . . . ability to critically and accurately assess, plan, intervene and evaluate the health and illness experiences of clients . . . ability to communicate effectively . . . [and] the ability to analyze, synthesize, and utilize knowledge . . . " (p. 6). Since that time, AACN published an updated document delineating education standards for Master's education in nursing (2011) and also published the 2006 Essentials of Doctoral Education for Advanced Nursing Practice. Both of these publications assist in guiding master's and practice doctorate CNS education today. It must be noted that both documents are useful in guiding core content but that neither document is specific to CNS practice.

The NACNS has published two documents to provide additional guidance for CNS education. In 1998, NACNS published its first statement on CNS practice and education. After just three years, 56% of CNS education programs were using the 1998 NACNS recommendations to guide their curriculum (Walker et al, 2003). NACNS published a second edition of education recommendations in 2004. The recommendations in this document build on the two previously published statements.

In 2008, CNS education was further standardized through publication of the Consensus Model for advanced practice registered nurse (APRN) licensure, accreditation, certification and education (APRN consensus work group). This document has since been used by certification bodies to guide certification eligibility criteria and by state boards of nursing to regulate advanced practice. Because this document outlined requirements for three separate courses focused on advanced pathophysiology, pharmacology, and physical assessment, these courses are now standard in all CNS programs. Additionally, this document included National Council of State Board of Nursing (NCSBN) criteria that certification bodies must require at least 500 supervised practicum hours. Therefore, in order to ensure that CNS graduates were eligible to take a post-graduation certification examination, CNS programs had to include at least 500 precepted practicum hours regardless of specialty. The requirements in the Consensus Model continue to drive regulation and certification requirements at this time.

It must be noted that the Consensus Model (APRN consensus work group, 2008) provided clarity related to the four roles of advanced practice: certified nurse anesthetist, certified nurse midwife, CNS, and nurse practitioner. The document established that APRN education would lead to preparation in one of these four roles, with further preparation in a population, of which there are six. The six populations include “family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women’s health/gender-related or psych/mental health” (APRN consensus work group, 2008, p. 5). Unfortunately, CNS certification exams do not exist for all populations. As of 2018, the American Nurses Credentialing Center (ANCC) offers one CNS-specific certification examination: Adult-Gerontology (ANCC, 2018). The American Association of Critical-Care Nurses offers CNS certification exams in Adult-Gerontology, Pediatrics, and Neonatal (AACN, 2018). Because certification exams are not available in all populations, CNS education programs will need to focus on those areas where certification exams exist.

As stated in Section One of this document, competencies listed in Section Two are role-based and do not address population or specialty. Similarly, the education recommendations contained in this section are also CNS role-based. Additional population and specialty education recommendations will need to be built on population and specialty competencies.

These national documents provide a general framework for preparing nurses at a Master's or an advanced practice level. The Essentials documents are broad and include core content and leaning outcomes that apply across roles and specialties (AACN 2006; AACN 2011). It is therefore important to outline CNS-specific content that ensures achievement of core competencies upon graduation from Master's or practice doctorate CNS programs.

Curricular Recommendations

As previously stated in Section One of this document, the competencies contained in Section Two apply to two levels of entry for CNS practice: Master's and DNP. We recognize multiple competency sets exist that can also be used to create CNS curricula, e.g. IPEC and QSEN. In this document, we are limiting our discussion to commonly used curriculum statements as opposed to competencies. For an example of QSEN curriculum alignment in the practice setting, readers are referred to Altmiller (2011) and for curriculum alignment with IPEC, readers are referred to Mayo and colleagues (2016).

NACNS recommends the following curricula content for CNS education:

1. Use AACN's Essentials for Master's (2011) and Doctoral Education for Nursing Practice (2006) to address core education requirements. As previously stated, neither document is specific to CNS practice.

2. Required courses in advanced pathophysiology, physical assessment and pharmacology should include the following content for CNS education:

a. Advanced physiology/pathophysiology should also include advanced science content such as epidemiology, psychobiology, or genetics. Advanced science content should include concepts and principles relevant for CNS practice, should reflect a balance between illness and disease etiologies, and should also be integrated throughout the curriculum.

b. In addition to performing advanced physical assessment, coursework must emphasize the evaluation of wellness, illness, psychosocial, functional, and environmental factors as well as risk behaviors to support the ability to make differential diagnoses.

c. Advanced pharmacology should include principles of pharmacodynamics, pharmacokinetics, pharmacotherapeutics, drug-drug, and drug-food interactions pertinent to this specialty. In situations in which the CNS desires prescriptive authority, an advanced pharmacology course should meet statute requirements.

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

a. Theoretical and empirical foundations for CNS practice

b. Theoretical and empirical knowledge of phenomena of concern that forms the basis for assessment, diagnosis, and treatment of illness and wellness within the CNS population and specialty

c. Theoretical and scientific base for the design and development of innovative evidence- based nursing interventions and programs of care

d. Clinical inquiry/critical thinking with advanced knowledge

e. Selection, use, and evaluation of health care technology/products/devices

f. Theories of teaching, mentoring, and coaching for use in all three spheres of impact

g. Influencing change

h. Systems thinking in regard to the organizational culture

i. Leadership for interprofessional collaboration

j. Consultation theory

k. Quality improvement and safety

l. Measurement and outcome evaluation methods

m. Evidence-based practice and knowledge translation

n. Interpersonal communication and leadership

o. Advocacy and ethical decision making

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 may 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:

1. Theoretical and empirical foundations for CNS practice:

DESCRIPTION: This content area focuses on theories, conceptual models, empirical knowledge and research that shape the CNS perspective.

EXAMPLES: Theories of health, illness, and wellness; health behavior (including self-care) and health behavior change; and theories of learning, stress, leadership, consultation, collaboration, and organizational development.

RATIONALE: Theoretical foundations and empirical knowledge serve as a basis for CNS practice.

2. Phenomena of concern:

DESCRIPTION: This content area focuses on theoretical and empirical knowledge of illness and wellness phenomena with nondisease and disease-based etiologies. Phenomena from all three spheres of impact should be incorporated into the curriculum.

EXAMPLES: Symptoms (e.g. nausea, fatigue, pain, dyspnea), cognitive impairment, dementia, iatrogenesis, developmental delay, end of life/dying, environmental hazards, impaired mobility, ineffective coping, impaired wound healing, safety, sleep disturbances, unsafe work place, and work place violence.

RATIONALE: Mastery of knowledge about the phenomena of concern to nursing prepares the CNS to differentially diagnose problems that are amenable to existing or innovative interventions, particularly in patients with complex and multifactorial health conditions. This knowledge also enables the CNS to (1) articulate nursing's unique contributions to patient/client care, (2) collaborate with other healthcare professionals, and (3) identify outcomes of care reflective of CNS interventions.

3. Design and development of evidence-based innovative nursing interventions:

DESCRIPTION: This content area focuses on the design and development of nursing assessments, evidence-based interventions, and programs of care. The content includes validating existing practices and identifying the need for innovations. This knowledge area 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. Innovations are focused toward cost-effectiveness and quality patient care.

EXAMPLES: Implementing innovative evidence-based, cost-effective 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; applying innovative interventions to decrease risk.

RATIONALE: This content is critical for CNSs because it requires graduate level analysis and synthesis of theory and evidence. CNSs develop innovative assessments and interventions with cost-effective outcomes, thus advancing the practice of nursing.

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 questioning practice for the purpose of advancing nursing practice, recognizing the nuances of patient experiences, and identifying the commonalties and uniqueness among population groups. These skills are used to determine the appropriate application of evidence to individuals or population groups. This content also includes the ability to reframe and hold biases and stereotypes in abeyance.

EXAMPLES: Critical thinking, diagnostic reasoning, pattern identification, clinical decision making, and problem-solving strategies.

RATIONALE: CNS practice requires the ability to understand and synthesize multiple perspectives, to be aware of personal thinking patterns, and to make effective decisions that enhance nursing practice and improve quality and cost-effectiveness.

5. Health care technology, products, and devices:

DESCRIPTION: This content area focuses on the evaluation, selection, and use of existing technology, products, and devices that support nursing practice and contribute to improved outcomes. Content may also focus on the development of new technology, products, and devices.

EXAMPLES: Evaluating patient education products; using and optimizing informatics; evaluating the sensitivity and specificity of a device to monitor a body function; using strategies to evaluate technology, products, apps, and devices from the perspectives of utility, cost-benefit analysis, ease of use, safety, and effects on patient outcomes; utilizing technology and products to improve patient safety; and evaluating ethical considerations. In addition, content includes consideration of strategies for standardization of products across a system so that errors and variance are reduced.

RATIONALE: CNSs are experts on technology, products, and devices in their respective specialty areas. CNSs serve as coaches to patients/clients, family members, and nursing personnel, and as consultants to purchasing departments and technology development companies. In an increasingly complex healthcare system, technology, products, and devices play a large role in supporting nursing practice.

6. Teaching and coaching:

DESCRIPTION: This content area focuses on theories and evidence about the factors that influence learning, health behaviors, and the teaching and coaching of learners who are patients and their significant others nurses, and other healthcare professionals.

EXAMPLES: Conducting needs assessments; designing health messages and health education materials to match literacy ability, cultural diversity, and physical capability; using theories and evidence to design teaching strategies to enhance learning; mentoring; and developing professional growth strategies.

RATIONALE: The CNS is responsible for developing innovative educational programs for patients, families, nurses, and other healthcare personnel. A continuing focus of CNS practice is teaching and coaching, particularly in the patient/client and nursing personnel spheres of impact. Approaches must be theory and evidence based, accessible, learner-friendly, cost-effective, patient-centered and lead to meaningful outcomes.

7. Influencing change:

DESCRIPTION: This content area focuses on theory and evidence-based approaches to implementing change in the practice setting.

EXAMPLES: Using theory and evidence to develop and use strategies to create change in the practice setting. Change strategies may involve developing relationships, empowerment, persuasion, negotiation, and collaboration. Experiences should include project management and knowledge translation. The focus of change strategies includes all three spheres of impact.

RATIONALE: Changes in healthcare delivery mandate more egalitarian and empowering relationships with patients/clients; require nurses to change the way they interact with patients and others; and necessitate that systems expand their services to include health promotion, prevention, and interdisciplinary practice groups to achieve desired outcomes and consumer satisfaction. These shifts require increased use of collaborative and mutually derived approaches that depend on influence, persuasion, and negotiation between CNSs and patients/clients, nurses, and other providers. Knowing how to influence organizational change through skillful negotiation is an essential part of CNS practice.

8. Systems thinking:

DESCRIPTION: This content area focuses on system theory and research to understand, evaluate, and predict individual, group, and organizational behaviors. The content includes skills in participating in change and policy-setting that influence the quality and cost of care within a system.

EXAMPLES: 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 and evidence related to healthy work environments, organizational behavior and change related to organizational learning and development should be included.

RATIONALE: Healthcare is delivered in a complex system. CNSs need to understand the context within which nursing care is delivered and develop strategies for influencing change and creating innovation.

9. Leadership for interprofessional collaboration:

DESCRIPTION: This content area focuses on developing leadership skills to create a collaborative environment for interprofessional teams. The content encompasses interpersonal qualities (e.g., respectful or relationship-based communication) needed to ensure a healthy work environment and shared goals of the organization. This content area also includes care coordination and transition management.

EXAMPLES: Developing facilitators and removing barriers to collaboration; working within the organizational culture; articulating nursing's unique contributions within the context of interprofessional teams; describing shared risks and benefits of collaboration; communicating with respect; engaging in risk-taking behaviors; and promoting the organization's vision.

RATIONALE: Successful nursing care delivery depends on the quality of interprofessional collaboration and is essential to improve the quality of care and ensure that care is safe and patient-centered (Interprofessional Education Collaborative, 2016).

10. Consultation theory:

DESCRIPTION: This content area focuses on consultation theory and research, and the associated process skills of serving as a clinical expert consultant.

EXAMPLES: 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; understanding revenue-generating processes; and using clinical expertise as a power base.

RATIONALE: Consultation skills are essential when working with patients/clients, nurses, or other healthcare providers. Consultation activities promote collaboration with other healthcare professionals, and lead to resolving complex patient problems, developing best practice models, and improving systems of care.

11. Quality improvement and safety:

DESCRIPTION: This content area focuses on theories and evidence related to quality improvement and safety. Understanding the science of quality improvement and patient safety is essential for CNSs to be effective in the practice setting.

EXAMPLES: Quality improvement theories and models; quality improvement processes; process mapping and evaluation; root cause analysis; monitoring of indicators; data analysis and interpretation from a QI perspective; communicating quality information; understanding and measuring a culture of safety; complex adaptive systems and human factors theory and evidence.

RATIONALE: A hallmark of CNS practice is ensuring patient safety and quality. In order to be effective, practicing CNSs must understand quality improvement models and processes.

12. Measurement and outcome evaluation methods:

DESCRIPTION: This content area focuses on clinical considerations of measurements (e.g., physiological, behavioral, psychosocial) required to assess and diagnose problems as well as research methods and techniques to evaluate nurse-sensitive outcomes consistent with the organization's mission and goals. These methods are also important in the development of databases relevant to evaluation of CNS practice outcomes, as well as efficacy of treatment at the patient and population level. Evaluation methods include various units of analysis within the system, the generation of cost-effectiveness/cost-benefit data, and monitoring of outcome indicators over time.

EXAMPLES: Selecting measurement instruments for evaluation of interventions at the individual, population, and system level, and critiquing their validity, reliability, and clinical applicability. Additional content includes consideration of system characteristics, resources, and variance; methods of selecting outcomes of interest; dissemination of nurse-sensitive and CNS outcomes both within and external to the organization; and communicating the fiscal implication of the outcomes measured.

RATIONALE: CNSs use instruments to measure phenomena of concern to nursing and to monitor indicators of quality pertinent to making system-level changes. CNS decision-making

must be based on data and compared to benchmarks to achieve optimal outcomes. Understanding measurement is critical to CNS leadership in assuring quality, cost-effective outcomes. CNSs must also provide evidence of dependable, cost-effective and high-quality care as outlined by the National Association of Clinical Nurse Specialists (2013). CNSs must continue to use evaluation strategies to demonstrate cost-effectiveness of programs. Program and outcome evaluation are necessary to enhance organizational performance.

13. Evidence-based practice and knowledge translation:

DESCRIPTION: This content area focuses on the evidence-based practice process for the purpose of translating knowledge into nursing practice.

EXAMPLES: Identifying problems and examining the evidence base of current practice, creating PICO questions, understanding and leveraging evidence hierarchies, creating effective search strategies, appraising evidence using reliable and valid tools, determining best practices, using project management skills and knowledge translation theory to apply evidence in practice, evaluating the outcomes of new evidence-based practices, and planning for sustaining gains and disseminating the outcomes of evidence implementation.

RATIONALE: Evidence-based practice and knowledge translation are important competencies for CNSs. The ability to conduct an analysis and synthesis of evidence is necessary in order to develop practice guidelines that will improve quality outcomes (IOM, 2001).

14. Interpersonal Communication and Leadership:

DESCRIPTION: This content area focuses on expert interpersonal communication with patients/families, nurses and nursing personnel, and representatives from other disciplines at all levels within the system.

EXAMPLES: Relationship-based communication, conflict management, crucial conversations, peer feedback, awareness of implicit bias, embracing diversity, and shared decision making with patients and significant others. Additional examples include leadership theory, development of leadership skills, team building and the ability to convey a shared vision for practice.

RATIONALE: The ability to effectively communicate is essential for CNS practice. CNSs must learn how to build trust and use that trust to improve practice. The process of building trust relies on effective interpersonal communication and leadership skills.

15. Advocacy and Ethical Decision Making

DESCRIPTION: This content area focuses on the use of ethical decision-making frameworks as a basis for advocating for patients/families, nurses, other health care providers, populations, and

the community as a whole. This area also focuses on the CNS role in policy development, influence and action as well as mentoring nurses in this process. As an advocate, CNSs have a responsibility to promote nursing's unique contributions toward advancing health to key stakeholders.

EXAMPLES: Ethical frameworks, analysis of ethical dilemmas, opportunities to advocate on behalf of others, health policy formulation, processes of influencing policy makers, taking action, and promoting nursing's contributions toward advancing health.

RATIONALE : CNSs serve as a voice for their patients and families and advocate for them to ensure quality care. They also advocate on behalf of nurses and serve as a liaison between nurses at the unit level and upper administration, providing a voice for nursing concerns. Finally, CNSs bring their voice to the policy arena, advocating for nurses and patient/nursing issues.

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 impact through preceptorships with CNSs. 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 healthcare providers appropriate to the specialty. However, the emphasis of CNS student clinical experiences must be on learning the CNS role and 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 give students opportunities to pursue specialty competencies if the education program purports to prepare students for practice in a specialty area. Faculty in many schools preparing CNSs report use of the NACNS Statement as required reading for their students to assist in learning about CNS core competencies. Other documents will be needed to supplement this and provide information about particular specialty competencies.

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 CNSs and other nursing and policy leaders.

The following table displays the alignment of the core CNS competencies with CNS outcomes, and curriculum content recommendations.

See Table 4: Alignment of Competencies, Outcomes and Curricular Recommendations

Summary

Recommendations for graduate education of the CNS address core competencies and outcomes of CNS practice within the three spheres of impact. The recommendations for curricula focus on essential content areas and threads, using some of the recommendations of the AACN, with NACNS-recommended additions to produce specific competencies of the CNS. For preparation in a specialty area, schools of nursing may provide additional courses and experiences beyond these recommendations.

In addition to the core content, CNS students should have opportunities to individualize their programs of study to meet personal career goals and develop specialty area competencies. Students should be precepted by CNSs who exemplify competencies and who can facilitate the students' socialization into the role.

It is recognized that some schools of nursing and their CNS programs and curricula do not address the recommendations of this document. It is recommended that faculty teaching in or planning to teach in a CNS program use this Statement to develop new programs or to revise curricula.

Section 5.

Criteria for the Evaluation of Clinical Nurse Specialist Master's , Practice Doctorate, and Post-Graduate Certificate Educational Programs

Introduction

The original document outlining criteria for evaluating clinical nurse specialist, master's, practice doctorate and post-graduate certificate educational programs was created by a national task force in 2009-2010. The document was validated in 2010-2011 by a large panel representing diverse professional nursing organizations. The final document was published in 2011 by NACNS (Validation Panel of the National Association of Clinical Nurse Specialists, 2011). The development and validation processes used at that time are published in the 2011 document. The criteria contained in this statement have been updated to reflect current competencies and practice.

Recommendations for using the criteria indicated they were to be used to evaluate CNS Master's, practice doctorate, and post-graduate certificate educational programs and to serve as an adjunct to existing national accreditation standards. In addition the standards could be used to guide development of new CNS programs and to conduct self-evaluation of new and existing CNS programs. This stated purpose of the criteria has not changed and the criteria can continue to be used as stated above.

This section of the statement includes main components: 1) criteria for the evaluation of CNS Master's, practice doctorate, and post-graduate certificate programs and 2) required and recommended documentation for evaluating CNS education programs. A toolkit that includes ideas regarding curriculum content, clinical learning experiences, and student-led change projects that relate to the three spheres of impact is available through NACNS.

Criteria for the Evaluation of CNS Master's, Practice Doctorate, and Post-Graduate Certificate Programs

The criteria for evaluating CNS Master's and practice doctorate educational programs follow. These are organized into five (5) sections – Program Organization and Administration; Program Resources, including faculty, clinical, and institutional; Student Admission, Progression and Graduation Requirements; Curriculum; and Program Evaluation. Each criterion is explained in greater depth in an Elaboration section, and the required/recommended documentation for each criterion is specified.

CRITERION 1. PROGRAM ORGANIZATION AND ADMINISTRATION

1-1. The CNS program operates within or is affiliated with an institution of higher education. The program is accredited by a nursing accrediting body that is recognized by the U.S. Department of Education.

Elaboration:

The CNS program must exist within an academic nursing unit that operates within or is affiliated with an institution of higher education. The program must be at the graduate level and accredited by a nationally-recognized nursing accrediting body (i.e., CCNE, ACEN, CNEA).

Documentation (Required):

- Description of program's relationship with the institution of higher education
- Evidence that the program is at the graduate level
- Evidence of current accreditation from a nationally-recognized nursing accrediting body

1-2. The purpose of the CNS program is clear, and the program outcomes are clearly aligned with the mission of the parent institution and the mission/goals of the nursing unit.

Elaboration:

The purpose of the CNS program must clearly define the population focus * area and any additional specialty * preparations. The program outcomes/competencies should reflect preparation at the graduate level and be congruent with the mission of the parent institution and the nursing unit.

* Throughout these Criteria, "population" and "specialty" are used in accord with the definitions outlined in the APRN Consensus Work Group (2008) document.

Documentation (Required):

- Evidence of congruence among the purpose of the CNS program, the mission of the parent institution, and the mission/goals of the nursing unit
- Evidence of congruence among the program outcomes/competencies, mission of the parent institution, and mission/goals of the nursing unit

1-3. The individual who has responsibility for the overall leadership or oversight of the CNS program:

- _has educational and/or experiential preparation for the CNS role;
- _holds a master's or doctoral * degree in nursing:
- _documents experience in graduate education;
- _is recognized/licensed by the Board of Nursing of the State in which the program is based; and
- _has responsibility for ensuring that the program adheres to national CNS educational standards.

Elaboration:

There must be a full-time faculty member designated to provide overall leadership or oversight of the CNS program. This individual must have educational and/or experiential preparation for the CNS role in a population focus area that is congruent with a focus of the program. Lead faculty must also meet state/territorial regulatory requirements regarding education

preparation, licensure, and certification. Based on the type of accreditation held by the nursing program, it may be necessary that lead CNS faculty hold national certification in role and population even if not required by state/territorial regulations. The faculty member designated to lead the CNS program is expected to keep abreast of current standards and trends in CNS education and practice and to ensure adherence to national CNS standards. Although not required, it is strongly recommended that the individual who has responsibility for the overall leadership or oversight of the CNS program be prepared at the doctoral level.

Documentation (Required):

- Description of the duties and responsibilities of the faculty member designated to lead the CNS program
- Evidence of how the faculty member designated to lead the CNS program advances the purpose, mission, goals, and outcomes of the program
- Curriculum Vitae of the faculty member designated to lead the CNS program, which documents educational preparation and/or national certification as a CNS in a population focus area congruent with one of the foci of the program
- Current credential as an APRN in the state/territory in which the program exists

Documentation (Recommended):

- List of publications and other scholarly activities relevant to CNS practice/education and membership/leadership in professional organization(s) that focus on advancing or documenting the impact of CNS practice/education

* Throughout these Criteria, “doctorate” refers to the practice or the research doctorate

CRITERION 2. CNS PROGRAM RESOURCES: FACULTY, CLINICAL, AND INSTITUTIONAL

Criterion 2. CNS Program Resources: Faculty, Clinical, and Institutional – FACULTY

2-1a. Faculty who teach in the CNS program have appropriate credentials, education and experience that prepares them for such teaching responsibilities.

2-1b. Faculty who teach CNS role and clinical practice courses have master’s, post-graduate, or practice doctorate preparation as a CNS.

Elaboration:

Faculty teaching CNS role or clinical practice courses in the CNS program must hold the academic credentials, qualifications, and experience that are needed to carry such teaching responsibilities. It is strongly recommended that faculty teaching in the practice doctorate CNS program hold an earned practice or research doctorate, or have a clearly-outlined plan for attaining such preparation.

Documentation (Required):

- Profile Table of all faculty teaching in the CNS program documenting each individual's credentials, education, certification(s), experience, and courses taught for the past two years
- Curriculum Vitae of all faculty members teaching in the CNS program
- Plan to attain doctoral preparation for each master's-prepared faculty member teaching in the practice doctorate CNS program who does not currently hold that degree

Criterion 2. CNS Program Resources: Faculty, Clinical, and Institutional – FACULTY

2-2. Faculty who teach in the CNS program maintain expertise in their area of specialization and contribute to the field (a) by engaging in scholarly projects and professional leadership activities that promote evidence-based practice and improve health outcomes, or (b) through other activities in one or more of the three Spheres of Impact (patient/client, nurses/nursing practice, organization/system).

Elaboration:

Faculty members teaching in the CNS program demonstrate expertise in at least one of the three Spheres of Impact through some form of faculty practice, which may include clinical care, scholarly projects (including evidence-based practice), consultation, or research with clinical implications.

Documentation (Required):

- Evidence of the practice or contributions made by each faculty member teaching in the CNS program, as they relate to one or more of the Spheres of impact.
- Examples of the leadership activities of faculty members teaching in the CNS program, including national/state/regional service in professional associations

- Evidence of the professional development activities of faculty members teaching in the CNS program that serve to help maintain expertise in the area of specialization and the area(s) of teaching responsibility

- Examples of the scholarly activities of faculty members teaching in the CNS program, including publications, grants, presentations, evidence-based practice contributions, etc.

Criterion 2. CNS Program Resources: Faculty, Clinical, and Institutional – FACULTY

2-3. Faculty who teach in the CNS program must be sufficient in number and expertise to teach all courses, support the professional role development of students, implement essential clinical learning experiences, develop policies, advise students, and engage in ongoing curriculum development and evaluation.

Elaboration:

It is essential to have an adequate cadre of full-time and part-time faculty teaching in the CNS program to provide quality learning experiences for students, engage in ongoing curriculum review and refinement, mentor students and junior faculty, guide preceptors, and provide continuity regarding implementation of the program.

Documentation (Required):

- Copies of teaching assignments for all faculty teaching in the CNS program for the past two years

- Plan to develop and/or maintain a cadre of qualified full-time faculty to teach in and maintain the quality and stability of the program

Criterion 2. CNS Program Resources: Faculty, Clinical, and Institutional – CLINICAL

2-4. A sufficient number of faculty and clinical preceptors are available to ensure quality clinical experiences for CNS students and provide adequate direct and indirect supervision and evaluation of students enrolled in clinical practice courses. Faculty/student ratios must conform to any State Board of Nursing requirements.

Elaboration:

Adequate and appropriately-credentialed faculty and clinical preceptors to teach the clinical components of the CNS program are essential for effective program implementation. The recommended ratio for direct supervision (by the faculty member or clinical preceptor) is 1:1 or 1:2. The recommended ratio for indirect supervision (by the faculty member) is 1:6 to 1:8. Such ratios ensure quality clinical learning experiences for students, as well as effective evaluation of student performance.

Documentation (Required):

- List of all full-time and part-time faculty, including credentials, involved in teaching clinical CNS courses during the past two years, indicating whether each provided direct or indirect supervision
- List of faculty:student and preceptor:student ratios for all CNS clinical courses taught during the past two years, indicating whether each was direct or indirect supervision
- Description of mechanisms for determining faculty:student and preceptor:student ratios and evaluating whether these provide quality outcomes
- Explanation of any variations in the recommended faculty:student or preceptor:student ratios noted in the Elaboration section above
- Documentation of State Board of Nursing requirements (when available) regarding faculty:student and/or preceptor:student ratios and how the CNS program meets those requirements

Criterion 2. CNS Program Resources: Faculty, Clinical, and Institutional – CLINICAL

2-5. When preceptors are involved in the clinical supervision of students, the faculty who teach in the CNS program retain ultimate responsibility for evaluating student performance and the quality of the clinical experiences.

Elaboration:

When preceptors are used by the CNS program, they are expected to provide evaluative feedback to students and faculty regarding the students' clinical performance. The criteria for

those evaluations are to be provided by faculty members teaching in the program, and they have ultimate responsibility for evaluating student performance and evaluating the quality of students' clinical experiences.

Documentation (Required):

- Criteria for selection/appointment of clinical preceptors
- Methods of communication between faculty and clinical preceptors regarding student performance and the adequacy of the clinical experience
- Evaluation criteria used to assess student performance in each CNS clinical course

Criterion 2. CNS Program Resources: Faculty, Clinical, and Institutional – CLINICAL

2-6. Preceptors, who are authorized to practice in the CNS role through educational preparation and/or CNS certification, supervise students in clinical practice experiences through direct or virtual interactions. Other professionals also may serve as preceptors for clinical experiences.

Elaboration:

Clinical preceptors must be educationally- and experientially-prepared to mentor students in the CNS role. If CNS preceptors are not available or additional professional expertise is deemed essential for the student's education, other professionals (e.g., master's- or doctorally-prepared nurse practitioners, physicians, nutritionists, social workers, psychologists, nurses, or other health professionals with advanced preparation and specialized expertise) may precept CNS students for circumscribed experiences.

Documentation (Required):

- Evidence that student clinical practice experiences are supervised by CNS preceptors or CNS faculty members
- Copies of agreements/contracts with all preceptors involved in the CNS program during the past two years
- Evidence that all preceptors hold the appropriate professional degree and credential

- Documentation of verification of all preceptors' credentials, educational or experiential preparation, and unencumbered professional license

- Description of a plan to increase the number of educationally- and experientially-prepared preceptors is provided when CNS preceptors are not available for essential supervision of students

Criterion 2. CNS Program Resources: Faculty, Clinical, and Institutional – CLINICAL

2-7. Preceptors who supervise CNS students in clinical settings are oriented to curriculum requirements, practice course objectives, and expectations regarding student supervision and evaluation.

Elaboration:

Preceptors are better able to supervise CNS students when they receive ample information about the specific course in which the student is enrolled and how the experience they are sharing with the student relates to the overall program outcomes/competencies. The preceptor's role in supervision and evaluation should be evident to all concerned – preceptor, student, and faculty. Page XX

Documentation (Required):

- Description of the way(s) in which preceptors are oriented to the CNS program outcomes/competencies, specific course objectives, and their responsibilities related to the supervision and evaluation of the student

- Copies of orientation documents provided to preceptors

Criterion 2. CNS Program Resources: Faculty, Clinical, and Institutional – CLINICAL

2-8. Clinical facilities are sufficient in quality and number to provide experiences that give CNS students ample opportunities for role development, implementation of nationally-validated CNS competencies in the three Spheres of impact (patient/client, nurses/nursing practice, organization/system), and meeting CNS/APRN certification/licensure requirements.

Elaboration:

Sufficient clinical facilities are essential to support student practice experiences in all three Spheres of Impact, to enhance role development, and to prepare students to meet certification/licensure requirements in the role and population focus. Student experiences in all three Spheres of Impact help them develop skills in all of the nationally-validated CNS competencies and expand their career opportunities.

Documentation (Required):

- Description of clinical facilities available and used for student practice experiences within the past two years
- Examples of the experiences available in clinical facilities regarding each Sphere of Impact
- Examples of student practice experiences related to each Sphere of Impact
- Examples of current agreements/contracts with facilities used for CNS clinical practice experiences (NOTE: All agreements/contracts must be on file)

Criterion 2. CNS Program Resources: Faculty, Clinical, and Institutional – INSTITUTIONAL

2-9. Resources are sufficient to support the ongoing professional development, scholarly activities, and practice of faculty who teach in the CNS program.

Elaboration:

Faculty members are expected to engage in professional development and scholarly activities, as well as continue their practice, in order to remain current. Such activities must be supported, at least in part, by the program.

Documentation (Required):

- Description of the support provided to faculty who teach in the CNS program that allows them to enhance their professional development, engage in scholarly activities, and engage in practice

Criterion 2. CNS Program Resources: Faculty, Clinical, and Institutional – INSTITUTIONAL

2-10a. Learning resources and support services for on-campus/face-to-face and online/distance environments are sufficient to ensure educational quality in the CNS program.

2-10b. Institutional resources, facilities, and services needed to support the development, implementation, and evaluation of the CNS program are available to faculty and students.

Elaboration:

Technology, library, faculty development, support systems, and other resources are essential to support faculty in designing and implementing teaching and evaluation methods in all courses in the CNS program and to ensure a quality educational experience. The institution, therefore, must provide resources, facilities, and services that are sufficient in number and quality to support faculty and students in all aspects of the CNS program.

Documentation (Required):

- Description of resources and support systems in place to support faculty in designing and implementing effective teaching and evaluation methods

- Description of how the institution supports faculty and students in the CNS program in the areas of resources, facilities, and support services (including technology support for distance education) to ensure program quality and student success.

CRITERION 3. STUDENT ADMISSION, PROGRESSION AND GRADUATION REQUIREMENTS

Criterion 3. Student Admission, Progression and Graduation Requirements

3-1. The CNS program builds on baccalaureate level nursing competencies and culminates in a master's degree, post-graduate certificate, or doctorate.

Since CNSs are advanced practice registered nurses, their education must be at the graduate level and build upon baccalaureate nursing competencies. In light of the many pathways for the educational preparation of nurses, graduate preparation for the CNS role may be at the

master's level, through a post-graduate certificate program, or through a practice doctorate program.

Documentation (Required):

- Evidence that the CNS program meets appropriate expectations outlined by national organizations for graduate and APRN programs

- Documentation that the CNS program builds on baccalaureate nursing competencies and, as appropriate to the degree being awarded, on nationally-recognized graduate level nursing competencies

Criterion 3. Student Admission, Progression and Graduation Requirements

3-2. Faculty who teach in the CNS program participate in developing, approving, and revising the admission, progression, and graduation criteria for the program

Elaboration:

The role of faculty teaching in the CNS program in developing and implementing admission, progression and graduation criteria related to that program must be clear. Such faculty must have the authority and responsibility to make decisions regarding student admissions and progression through the program.

Documentation (Required):

- Description of the admission and progression criteria for students in the CNS program

- Evidence of how faculty teaching in the CNS program are involved in making decisions about admissions to that program

- Evidence of how faculty teaching in the CNS program are involved in establishing progression guidelines and making decisions related to student progression through that program

- Aggregate data about qualifications of students admitted to the CNS program, their progression through it, graduation rates, and graduates' success on national certification exams (if available) and state licensure/recognition as a CNS/APRN

Criterion 3. Student Admission, Progression and Graduation Requirements

3-3. All students in the CNS program must hold unencumbered licensure as an RN prior to and throughout their enrollment in CNS clinical courses.

Elaboration:

Since the CNS program prepares students for an advanced practice role in nursing and requires their involvement in patient care during clinical courses, students must meet legal requirements to practice as a registered nurse.

Documentation:

- Description of how the current RN license of all students in the CNS program is verified
- Documentation that files are maintained showing evidence of licensure validation

CRITERION 4. CNS CURRICULUM

Criterion 4. CNS Curriculum

4-1. The curriculum is congruent with state requirements, national standards for graduate APRN programs, and nationally-recognized master' level or DNP CNS competencies.

Elaboration:

The CNS curriculum should incorporate appropriate theory and clinical courses consistent with state requirements and nationally-endorsed standards, guidelines and competencies for graduate, APRN and CNS programs. Graduates of the program should be prepared to practice in the CNS role and be successful on a national certification exam appropriate to the population-focused area. Preparation for meeting graduate-level CNS competencies and effectiveness within the three CNS Spheres of Impact should be reflected in the curriculum. Post-graduate certificate program graduates are expected to meet the same CNS competencies as master's or practice doctorate program graduates.

Documentation (Required):

- Copy of the program of study showing core, role, population and, if appropriate, specialty courses for each track or where core, role and population competencies are integrated

- Syllabus for each course in the CNS program, including course descriptions, objectives, credits, didactic/clinical allocations, and relationship to nationally-recognized graduate core, APRN core, CNS role/population-focused core standards, and the three Spheres of Impact

- Description of how the program uses state requirements, nationally-endorsed standards and guidelines, and each of the following to develop and refine the curriculum:

  - Nationally-endorsed CNS master's and/or practice doctorate competencies

  - AACN Master's Essentials (2011) and/or DNP Essentials (2006);

  - The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education (2008)

- Evidence that the curriculum prepares students to meet the criteria for eligibility to take the appropriate national certification examination (when available) and for state licensure/recognition as a CNS/APRN

Criterion 4. CNS Curriculum

4-2. The CNS program requires a minimum of 500 supervised clinical (clock) hours for master's and post-graduate preparation. A minimum of 1,000 supervised clinical (clock) hours are required for post-baccalaureate practice doctorate preparation.

Elaboration:

CNS students must have an opportunity to practice the CNS role in settings related to the population/focus area and, if appropriate, specialty of the program under the supervision of a CNS faculty member and/or a qualified CNS preceptor. "Clinical (clock) hours" refers to hours in which the student implements the CNS role in one or more of the Three Spheres of Impact. (Skills lab hours and physical assessment practice sessions are not included in the calculation of "clinical (clock) hours.")

Combined CNS/nurse practitioner programs must include clinical experiences in both the CNS and NP roles and population/focus area and must prepare students to be eligible for

certification as a CNS. A minimum of 500 clinical (clock) hours must be spent in post-graduate programs preparing for the CNS role and population/focus area of practice. A minimum of 1,000 clinical (clock) hours must be spent in post-baccalaureate programs preparing nurses for the CNS role at the practice doctorate level.

CNS programs preparing graduates for practice in a specialty area of practice in addition to the population/focus area must document how clinical experiences address both. It is expected that the number of required clinical hours will be greater for a program that prepares students for CNS practice in a specialty area in addition to the population/focus area.

Documentation (Required):

- Evidence that validates a minimum of 500 clinical (clock) hours in the master's and post-graduate certificate CNS program

- Evidence that validates a minimum of 1,000 clinical (clock) hours in the post-baccalaureate practice doctorate program

CRITERION 5. CNS PROGRAM EVALUATION

Criterion 5. CNS Program Evaluation

5-1. There is a comprehensive evaluation plan for the CNS program that addresses the curriculum, faculty resources, student outcomes, clinical sites, preceptors, and program resources.

Elaboration:

A comprehensive plan for evaluating the CNS program that specifies the what, who, when and how of data collection is essential to ensure continued program quality. The plan must provide for regular reviews (e.g., every five years or more frequently as certification or national standards are updated/ revised), document how results of the evaluation are used for program improvement, and describe how faculty determine that program outcomes/competencies are met.

Documentation (Required):

- Copy of the comprehensive evaluation plan that describes systematic evaluation of the didactic and clinical experiences, preceptors, clinical sites, and faculty involved in the CNS program

- Evidence that the evaluation of the CNS program is integral to the nursing unit's overall Evaluation Plan

- Documentation of how evaluation results have been used for program improvement

- Timeline for the ongoing, systematic evaluation of the CNS curriculum

- Documentation of regular, formal reviews of the CNS curriculum by faculty teaching in that program

Criterion 5. CNS Program Evaluation

5-2. The CNS program collects and aggregates data from a variety of sources to evaluate achievement of program outcomes.

Elaboration:

The CNS program must develop and implement a plan to evaluate the extent to which program outcomes/competencies have been achieved, incorporating the perspective of students, alumni, graduates' employers, clinical partners/preceptors, and other significant stakeholders. Aggregate data from program evaluations should be reviewed regularly by faculty teaching in the CNS program and used for ongoing improvement of the program.

Documentation (Required):

- Instruments/methods/measures used to collect data needed for a comprehensive program evaluation. Such measures may include the following: graduate/alumni satisfaction, employment following program completion, employer satisfaction, certification pass rates, program retention and graduation rates, etc.

- Aggregate data (such as average time to complete the program, graduation rates, and pass rates on national certification exam and state licensure/approval as a CNS/APRN) from students, alumni, graduates' employers, and other stakeholders for the past two years

- Reports of analyses of data that document CNS program strengths, areas needing improvement or refinement, and strategies designed to address areas of concern

- Examples of program changes that have been made, based on findings from the program evaluation

Documentation (Recommended):

- Minutes of curriculum meetings where program outcome data were analyzed and recommendations for program improvement were formulated

Criterion 5. CNS Program Evaluation

5-3. Faculty who teach and students who are enrolled in the CNS program have input into the ongoing development, evaluation and revision of the program.

Elaboration:

Faculty who teach in the CNS program are knowledgeable about national practice standards, guidelines for graduate nursing education, and guidelines for CNS education. They also understand the curriculum structure and content, as well as the learning experiences that are necessary to adequately prepare CNSs for their evolving role. Students also have a vested interest in the program, since they are the ones who experience it and who desire to be exceptionally well-prepared to assume the CNS role upon graduation. Therefore, both students and faculty should participate in designing, evaluating, and revising the CNS program.

Documentation (Required):

- Description of processes in place that provide for faculty and student input into the development, evaluation, and refinement of the CNS curriculum.

- Examples of how students and faculty have been engaged in curriculum development, evaluation, and refinement

Documentation (Recommended):

- Minutes from CNS faculty and/or graduate program meetings that illustrate curriculum development and decision making by faculty
- Minutes from CNS faculty meetings that illustrate how student input is incorporated into decisions related to curriculum design and implementation

Criterion 5. CNS Program Evaluation

5-4. The CNS curriculum is evaluated on an ongoing basis, using relevant data to inform revisions.

Elaboration:

In order to ensure that it remains current and relevant, the CNS program must be formally evaluated, and such evaluation should occur regularly (e.g., every 5 years or more frequently as certification or national standards are updated/revised, or as major changes in the program/curriculum occur). Data from such evaluations, as well as the need to be responsive to changes in certification or national standards, are essential to guide decisions about refinements that may be needed to provide quality education that prepares graduates for effective practice in the CNS role.

Documentation (Required):

- Sample reports of data collection activities
- Examples of how outcome data have been used to revise/refine the CNS program

Criterion 5. CNS Program Evaluation

5-5. Faculty who teach in the CNS program are evaluated regularly, according to parent institution or nursing unit policies.

Elaboration:

In order to ensure that faculty continues to be appropriately-credentialed, effective teachers, current in their knowledge of CNS practice and contributing professionals, there must be a plan for when, how, and by whom regular evaluations of all faculty who teach in the CNS program are conducted.

Documentation (Required):

- Methods used to evaluate faculty who teach in the CNS program (e.g., annual activity reports, student evaluations of teaching effectiveness, peer evaluations of teaching and scholarship)

- Description of when faculty teaching in the CNS program are evaluated, by whom, and how data from those evaluations are used to promote ongoing faculty development and program quality

- Tools/Instruments used to gather evaluative data about faculty who teach in the CSN program

Criterion 5. CNS Program Evaluation

5-6. The clinical agencies and preceptors utilized for the CNS program are evaluated annually by faculty members and students.

Elaboration:

There must be clearly-defined processes and methods to evaluate (a) the effectiveness and appropriateness of clinical sites and (b) the qualifications and effectiveness of preceptors engaged in supervising and evaluating CNS students.

Documentation (Required):

- Description of procedures and methods used by students enrolled in and faculty teaching in the CNS program to evaluate clinical facilities used in the program.

- Description of how clinical facilities, including those in locations for distance education students, are selected and evaluated

- Description of procedures and methods used by students enrolled in and faculty teaching in the CNS program to evaluate the preceptors involved in supervising and evaluating students

- Tools/Instruments used to gather evaluative data about clinical facilities used and preceptors who supervise and evaluate CNS students

Criterion 5. CNS Program Evaluation

5-7. Evaluation of students is cumulative, multi-method, and incorporates clinical observation of performance by faculty who teach in the CNS program and preceptors who supervise students in practice experiences.

Elaboration:

Student performance must be evaluated overall and should include an evaluation in each clinical course according to a defined evaluation plan. Such evaluations should be comprehensive, use multiple means to gather data about performance, and include observations (in-person, virtually, or through the use of various technologies) of students' performance by both the faculty member teaching the CNS clinical course and the preceptor who provides ongoing supervision of student in the clinical facility.

Documentation (Required):

- Description of the plan for evaluating student performance, including the methods used to evaluate their clinical performance, the frequency of evaluations, and the responsibilities of faculty and preceptors in the evaluation process

- Description of how feedback is provided to students by faculty and preceptors regarding their performance and their progress in meeting program outcomes/competencies

Documentation (Recommended):

- Examples of the tools/Instruments used to evaluate students' performance in the CNS program, including both didactic and clinical courses

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