THE CHARACTERISTICS OF THE
CLINICAL NURSE SPECIALIST
ROLE IN NEW ZEALAND

A thesis presented in partial fulfilment of the
requirements for the degree of

Master of Nursing

At the
Eastern Institute of Technology
Hawke’s Bay, New Zealand

Jennifer Roberts
2009
ABSTRACT

The concept of advanced and specialist roles is not new in nursing practice and raises internationally relevant issues (Jacobs, 2007, Hamric, Spross & Hanson, 2005). It is widely acknowledged that such roles make valuable and positive contributions towards achieving better health outcomes for a variety of patient populations (Gardner, Carryer, Dunn & Gardner, 2004). While much has been written about the newly established Nurse Practitioner role in New Zealand, the Clinical Nurse Specialist (CNS), an equally valuable advanced practice role, is less explored.

This research describes the characteristics of the CNS role in New Zealand by investigating how the CNS role is defined and experienced. Undertaken as a case study, the research used sequential mixed methods to investigate CNS job descriptions as documented by New Zealand District Health Boards and the experiences of practicing CNSs through semi-structured interviews.

Fifteen job descriptions were analysed in phase one using both quantitative and qualitative methods. Overall there were inconsistencies found in how the CNS roles were defined, most notably concerning requirements for Post Graduate qualifications and Professional Development Recognition Programmes. Thematic analysis of the documents generated four themes relevant to the CNS role. The CNS was defined as a leader, a clinical expert, coordinator and an educator.

The results of the analysis of CNS job description documents lead to focused questions being formulated for the interviews in phase two of the study. Five key themes emerged from the interview data in which the CNSs described their roles as being: a leader, the driving force of the specialty; an autonomous expert; a collaborator with integral relationships; an educator and sharer of expertise. The role also required extended time and care.

While some consistent descriptions of the CNS role were found in both the job descriptions and the interviews, the research discussion focuses more on the inconsistencies. These exist around what Post Graduate qualifications are required and what is meant by ‘expertise’ in the CNS role. Specifically discussed is the absence of a defined scope of advanced practice for the CNS.
ACKNOWLEDGEMENTS

I would like to acknowledge the people who have guided me and contributed to this work:

Firstly, to my supervisors Dr. Shona Thompson and Sue Floyd at the Eastern Institute of Technology, Hawke’s Bay, I thank you for your support, encouragement, your knowledge of the research process, and your thorough and constructive editing. This allowed me to complete this work.

To the nurses who participated in this research. Your work has provided truly great examples of exceptional nursing practice.

Thank you to Drs. Cap and Susan Jacobs for fostering in me an enquiring mind and the pursuit for knowledge (and for being great parents!). To my husband and family for their patience and for making it all worthwhile.

Finally I would like to acknowledge all the nurses who I have worked with over the years who have taught and inspired me.
# TABLE OF CONTENTS

ABSTRACT ........................................................................................................................ 2  
ACKNOWLEDGEMENTS ................................................................................................. 3  
TABLE OF CONTENTS .................................................................................................... 4  
FIGURES ............................................................................................................................. 6  
TABLES .............................................................................................................................. 6  

**Chapter One** ............................................................................................................... 7  
INTRODUCTION ............................................................................................................... 7  
Introduction ........................................................................................................................... 7  
Background and Significance of the Research ................................................................. 7  
International Perspective of the CNS Role ........................................................................ 8  
National Perspective of the CNS Role ............................................................................... 8  
The Researcher’s Interest .................................................................................................... 9  
Aims of the research ......................................................................................................... 10  
Thesis Outline .................................................................................................................... 11  
Conclusion ....................................................................................................................... 12  

**Chapter Two** ............................................................................................................. 13  
LITERATURE REVIEW .................................................................................................. 13  
Introduction ................................................................................................................................. 13  
Defining Advanced Practice Nursing .................................................................................. 14  
The Expert Nurse ................................................................................................................... 15  
The Clinical Nurse Specialist .............................................................................................. 17  
Conclusion ....................................................................................................................... 20  

**Chapter Three** ......................................................................................................... 21  
METHODOLOGY ............................................................................................................ 21  
Introduction ................................................................................................................................. 21  
The CNS Role as a Case Study ........................................................................................... 21  
A Qualitative or Quantitative Approach? .......................................................................... 23  
A Mixed Method Approach ................................................................................................. 24  
Phase One: A Document Content Analysis of District Health Board CNS Position Descriptions ... 25  
Phase Two: Semi-Structured Interviews with Clinical Nurse Specialists .......................... 26  
Delimitations of the Study .................................................................................................... 27  
Limitations of the Study ....................................................................................................... 28  
Ethical considerations ......................................................................................................... 28  
Conclusion ....................................................................................................................... 29  

**Chapter Four** ............................................................................................................ 30  
PHASE ONE: DATA ANALYSIS OF CNS JOB DESCRIPTIONS .................................. 30  
Introduction ....................................................................................................................... 30  
QUANTITATIVE DATA RESULTS .................................................................................. 30  
QUALITATIVE DATA RESULTS .................................................................................... 35  
Conclusions of the findings of Phase One ........................................................................ 40
FIGURES

Figure 1  Qualifications listed as being required for the CNS role. . . . . . . . . p. 31
Figure 2  Areas which experience was listed as required for CNS positions. . p. 33

TABLES

Table 1  Summary of DHB CNS job descriptions. . . . . . . . . . . . . . . . . . . . . p.25
Chapter One

INTRODUCTION

Introduction

The Clinical Nurse Specialist (CNS) role is internationally considered a valuable advanced nursing practice role contributing significantly to the well being of specific patient populations. New Zealand, like many countries, is developing unique advanced nursing practice roles in order to meet the needs of increasing complex health care needs. The CNS operates within many New Zealand District Health Boards but the role remains relatively unexplored in New Zealand literature.

This research seeks to describe the CNS role in New Zealand. By creating a sequential case study of the CNS role, mixed methods are used to describe the CNS role in New Zealand. Phase one combines quantitative and qualitative document content analysis of District Health Board (DHB) CNS job descriptions. Phase two is semi-structured interviews with CNSs employed at DHB’s in the central region of New Zealand. This chapter provides as introduction and background to the research. The researcher’s interest in the topic is presented, the aims of the research stated and an outline of the thesis described.

Background and Significance of the Research

The concepts of advanced nursing roles and specialization in nursing practice are not new and are internationally relevant issues (Jacobs, 2007, Hamric, Spross & Hanson, 2005). It is widely acknowledged in the literature that advanced nursing practice roles make valuable and positive contributions towards achieving better health outcomes for a variety of patient populations (Gardner, Carryer, Dunn & Gardner, 2004). There is a wealth of literature available about the newly established Nurse Practitioner role in New Zealand but considerably less about the Clinical Nurse Specialist (CNS) which this research suggests is an equally valuable, but lesser explored, advanced practice role. Researching the Clinical Nurse Specialist role in New Zealand is a significant research topic due to the importance of advanced nursing practice roles both nationally and internationally.
International Perspective of the CNS Role

The International Council of Nurses (ICN) recognizes the CNS role as an advanced practice nurse. The ICN define an advanced practice nurse as

A Nurse Practitioner/Advanced Practice Nurse is a Registered Nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Masters Degree is recommended for entry level (International Council of Nurses (ICN), 2005, p.5).

The CNS, the Nurse Anaesthetist, Nurse Midwife and Advanced Nurse Practitioner, all come under this umbrella definition (ICN, 2005).

The CNS role was born of specialty nursing. In the history of nursing the emergence of specialty nursing can be linked to the discovery of chloroform as an anaesthetic in the 19th century and specialty nurses assisting with anaesthesia in the United States (Hamric, Spross & Hanson, 2005). The Clinical Nurse Specialist role is also historically linked with psychiatric nursing which is recognized as the first clinical specialty in nursing, when specialized training programmes commencing in the 1880’s (Hamric, Spross & Hanson, 2005). However it was in the 1970’s in the United States when advanced Nursing practice became decisively established through advancements in education preparation and clinical practice roles for both the CNS and Nurse Practitioner (Hamric et al, 2005).

Contemporarily the CNS role is established in the United States, Australia, Taiwan, China, Japan, New Zealand and the United Kingdom (Hamric et al, 2005 & Chen Chiu-Hui, 2009). The exact definition and practice scope of the CNS role of each country appear to be influenced by a myriad of factors such as, economic climate, culture, education and practice standards and model of health care delivery (Hamric et al, 2005 & Ciu-Hui Chen, 2008).

National Perspective of the CNS Role

It is unclear in the literature when CNS’s became widely employed throughout New Zealand (NZ) District Health Board’s (DHB). The title was discussed as early as 1976 in
the New Zealand Nurses’ Association’s policy statement on nursing in New Zealand. It appears that the CNS role became fairly common in the late 1990’s with key discussion about the role appearing in the Report of the Ministerial Taskforce on Nursing, (1998). A role definition was released by the Nurse Executives of New Zealand in 1998, which stated,

A Clinical Nurse Specialist role is undertaken by a nurse with experience in the clinical specialty and advanced learning in that area of specialist cares. The nurse, during episodes of care, undertakes assessment, organizes tests, plans and initiates care to meet the special needs of an individual or group of patients with particular health problems (Peach, Cooper-Liversedge, Russell & Hayes, 1998, p.3).

It is clear that the CNS role is now widespread throughout New Zealand and it is deemed a ‘senior nurse role’ in the District Health Board Multi-Employer Collective Agreement (MECA) (New Zealand Nurses Organization, 2007). There are many CNSs employed by District Health Boards around New Zealand, however the role is unclear, lacking national consistency or published literature.

Buresch & Gordon state, “Being silent and unknown is a persistent problem in nursing” (1998, p.20). It is hoped that in articulating an accurate description of the CNS role in the unique NZ context may give the profession an opportunity to reflect on and recognize the work of the CNS. “Only nurses can tell the public what expert nursing care consists of and what is necessary to protect and defend it” (Buresch & Gordon, 198, p.7).

The Researcher’s Interest

I have had many formal and informal titles in my nursing professional lifetime: The Student, Registered Nurse, Registered Comprehensive Nurse, Staff Nurse, Clinical Nurse Specialist, Associate Nurse Unit Manager, and Team Leader. I have always had an interest in the organization of nurse’s work and the factors that may influence it. Across the organizations where I have worked I have observed that different hierarchical structures, including nurse roles and associated titles, appear to have a big impact on both nurse attitudes and job performance.
I worked as a CNS in Melbourne, Australia from 2002-2006 in Cardiac Care Units and Cardiac Catheter Labs in both the public and private sectors. I am particularly interested in the CNS role as it allowed me the hands-on clinical work I loved while also fostering my potential in other roles such as leadership, teaching, policy development and working closer with other disciplines and hospital departments.

When I returned to work in New Zealand in 2006 I noticed the CNS role was in use in New Zealand though it differed to that in Australia. Most of the literature around the role originates from the United States which again presents a different picture of the CNS. From my experience and observations I developed a hunch that the CNS role in New Zealand was perhaps a bit ‘messy’ and ill defined. I felt this stemmed from a lack of attention due to the recent development of the Nurse Practitioner role in New Zealand. I also wondered what differentiates CNS practice to that of an experienced ‘expert’ Registered Nurse. My motivation for this study comes from these informal questions, and my belief that the CNS role has the potential to positively influence nurse job satisfaction improve nursing care delivery and ultimately improve patient outcomes.

My research, therefore, asks the question:
What are the characteristics of the CNS role in New Zealand?

**Aims of the research**

This research aims to answer the research question, what are the characteristics of the CNS role in New Zealand, by investigating how the CNS role is defined and experienced in this country. The research is undertaken as a case study of the CNS role. It draws on data from two main sources, using a mixed methods approach to comprehensively explore and describe the CNS role. Data is derived from an analysis of CNS job descriptions as documented by NZDHBs, and semi-structured interviews with CNSs. Overall a qualitative general inductive approach is used with some quantitative analysis made of aspects of the CNS job description document analysis in order to meet the following aims:

- To establish what is known about the CNS role in NZ.
- To describe the qualities and characteristics of the CNS role.
- To compare and contrast the NZ CNS role with how the role is described in international literature.
To contribute to national discussion and knowledge of the CNS role.

**Thesis Outline**

**Chapter One: Introduction**
The introductory chapter has provided background to the research. The significance of the research has been discussed. The research question and aims have been stated.

**Chapter Two: Literature Review**
A comprehensive review of both national and international literature of the CNS role and expert practice has been undertaken and is described in this chapter. The literature has been sourced from key texts, journals and internet databases.

**Chapter Three: Methodology**
This chapter describes the design of the research and the rationale for the selection of the design is discussed. The two phases of the research are explained, data collection, participant recruitment, data analysis and ethical considerations are outlined.

**Chapter Four: Phase One Data Analysis**
This chapter presents the findings of the first phase of data analysis which is an analysis of documented CNS job descriptions. Both qualitative and quantitative data findings are discussed.

**Chapter Five: Phase Two Data Analysis**
This chapter presents the second phase of the research findings which is based on interviews with practicing CNSs. Here the qualitative themes that arose from the interviews of participating CNSs are presented.

**Chapter Six: Discussion**
Chapter six presents a discussion of the research. This chapter compares and discusses the findings from phase one and two of the research.
Chapter Seven: Conclusions and Recommendations

In this final chapter the research question and aims are revisited. A summary of findings is presented. The potential implications for nursing practice are outlined and recommendations for future research are made.

Conclusion

This chapter has introduced the research topic by giving a national and international perspective of the background and significance of the CNS role. The researcher’s interest in the topic has been outlined. The research question has been stated, the aims of the research delineated and the thesis chapters have been described.
Chapter Two

LITERATURE REVIEW

Introduction

This chapter presents a review of both national and international literature considering the Clinical Nurse Specialist role. A literature review is defined as, “a systematic and critical review of published papers on a particular topic” (Schneider, Whitehead, Elliot, LoBiondo-Wood & Haber, 2007, p.47). It is intended to, “examine the knowledge base to inform…or guide original research” (Schneider et al, 2007, p.47).

There are many names given to advanced nursing roles which is a topic considered in the following discussion. The literature reviewed in this chapter seeks to address the following questions:

What advanced nursing practice roles other than the Nurse Practitioner are there in New Zealand?

How are the expert nurse and clinical nurse specialist defined in the literature?

What are the differences and/or similarities between an expert nurse and clinical nurse specialist?

This exploration will identify what is known about the expert nurse and clinical nurse specialist roles. Definitions of both roles will be sought. The strengths and weaknesses of the literature will then be critically analyzed and determine where, if any, gaps exist in the current body of knowledge regarding the CNS role.

The reviewed literature was accessed electronically, primarily through CINHAL and Proquest databases. Key search terms included, ‘expert nurse’, ‘clinical nurse specialist’ and ‘advanced nursing practice’. The search was limited to articles published in the past ten years (1998-2008). Reference lists of relevant papers were scanned manually to
identify further literature of relevance. Additionally, a hand search was conducted through library journal holdings and key text references have also guided this review.

**Defining Advanced Nursing Practice**

Advanced nursing practice is an international phenomenon (Jacobs, 2007) and advanced practice roles are established in many countries, including Australia and New Zealand (Elsom, Happnell & Manias, 2006 & Jacobs, 2007). The concept of specialized, expert or advanced nursing is not new. Hamric, Spross & Hanson, (2005) suggest advanced nursing practice can be identified as early as the nineteenth century in the United States during the Civil War and the discovery of chloroform as an anaesthetic agent.

Currently in New Zealand the most obvious example of the advanced practitioner is the recently established Nurse Practitioner (NP) and much has been written about this role and its contribution to health care (Dunn, 1997 & Gardner, Carryer, Dunn & Gardner, 2004). However, the specific role and contribution of the expert nurse and clinical nurse specialist (CNS) in New Zealand remains relatively unexplored.

Based on internationally and nationally accepted definitions, the author suggests that expert nurses and CNS’s fall under the umbrella of advanced nursing practice. The International Council of Nurses (ICN) state,

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

The Nursing Council of New Zealand defines advanced practice as that which, “reflects a range of highly developed clinical skills and judgments acquired through a combination of nursing experience and education” (ICN, 2005, p.4). This definition is much less prescriptive than the ICN’s where aspects of the role are left open to interpretation. One may ask, who qualifies as an advanced practitioner? It seems from the literature that NPs are well defined both nationally and internationally (Gardner et al, 2004) however, in New Zealand, other advanced practice roles are struggling to find consistent definitions, titles and scopes of practice.
The Expert Nurse

A generic definition of an expert is someone with a high degree of knowledge or skill in a particular field as the result of experience or training (Mirriam_Webster’s online Dictionary, n.d.). It is generally accepted in nursing that Benner’s (1984) work, which illustrates how nurses acquire skills and experience, provides a cornerstone definition of expert practice (cited in Patterson, 1987 & Pelletier, Duffield, Nagy & Mitten-Lewis, 2000). Benner’s model describes five levels of clinical expertise; novice, advanced beginner, competent, proficient and expert (1984). In New Zealand the National Professional Development and Recognition Programmes (PDRP) framework (2005) has adapted this description and proposes four levels of practice; the graduate (novice), competent, proficient and expert registered nurse (National Nursing Organisation, 2005).

Defining who and what is ‘expert’ remains difficult. It is clear though that expertise is not merely developed by years of experience, though they are a requisite, (Benner, 1984) but a combination of educational preparedness, proven skills and experience (Pelletier et al, 2000, Benner, Tanner & Chesla, 1997 & Borbasi, 1999). Expertise is a blend of practical and theoretical knowledge found in prior experiences (Benner, 1984). Benner explains that expertise, “develops through a process of comparing whole similar and dissimilar clinical situations with one another, so an expert has a deep background understanding of clinical situations based upon many past paradigms” (1984, p. 294).

Amongst the literature there appears to be commonalities in what constitutes expert. The qualities most referred to are; expert delivery of care, facilitating change and quality improvements, education of self (post graduate) and in the workplace to colleagues and patients, active involvement in research, functioning as a leader, and cultural and ethical fluency (National Nursing Organisations, 2005, Castledine, 1999 & Borbasi, 1999). The most important quality is considered to be the delivery of expert care which is comprehensively outlined in earlier literature (Patterson, 1987 & Benner, 1984). It appears in more recent literature that emphasis is shifting from the delivery of care to the multitude of roles the expert is additionally expected to fulfil, such as leader, researcher, teacher, change agent, policy writer, professional spokesperson and so on (Castledine, 1999 & National Nursing Organisations, 2005). The author questions how an expert’s
clinical focus can be maintained in such a multifaceted role. It is as though providing expert clinical care (to patients) is no longer enough to qualify an individual as an expert nurse.

The literature on expert nurses consists largely of commentaries about what qualities characterize expert nurses (Benner, Tanner & Chesla, 1997 & Castledine, 1999) though there are a few noteworthy Australian studies of broader issues. Pelletier et al (2000) surveyed expert nurses to determine what they saw as the most essential skills, attitudes and knowledge to practice. This study found a gap exists between ideal and actual practice, however the sample of experts was made up of clinical nurse educators rather than nurses delivering care. Data collection was via a questionnaire of itemized skills, attitudes and nursing qualities which the clinical nurse educators were asked to rate in importance on a Likert Scale. This method, using a prescribed list, possibly missed other important qualities as the questionnaire could not have encompassed all the ‘qualities’ of what constitutes an expert.

In Borbasi’s (1999) phenomenological study of expert practice, daily practices of expert RN’s, direct patient care and the nature of the nurses’ skills are described in rich detail. Borbasi (1999) found, as did Benner in 1984, that expertise in nursing is still undervalued and to some extent invisible. Benner stated, “clinical expertise has not been adequately described or compensated in nursing and the lag in description contributes to the lag in recognition and reward” (1984, p.11). Borbasi concludes that the expert nursing care provided by her ‘experts’ was, “undervalued to the point of being ignored” (1999, p.28). Her research aimed to make visible the expert skills that parallel expert knowledge to illustrate their actual contribution. Her sample of experts was comprised of CNSs so the assumption is made in this study that a CNS is, in fact, an expert.

No research on the expert nurse in New Zealand (NZ) was found, however, with the introduction of and national use of Professional Development Recognition Programmes (PDRP), it is assumed that more and more nurses will be identified as experts in the future. The NZ definition of expert is considered to be a level four Registered Nurse on the PDRP (National Nursing Organisations, 2005). The criteria to obtain this level has not been standardized to apply to nurses in many settings, however for clear definitions
and competencies to be accepted and understood in the NZ setting more research needs to be done.

Benner (1984), states there is a wealth of untapped expert knowledge embedded in the practices and know-how of expert nurses that remains unrealized until nurses are able to articulate it. Changes in NZ legislation, such as the Health Practitioners Competence Assurance Act (2003), professional/industrial negotiations (MECA, 2007) and the national use of the PDRP, have contributed significantly in addressing this lack of articulation in NZ.

**The Clinical Nurse Specialist**

There is a wealth of literature regarding the CNS role, most of which originates from the United States (US). The role and title has been in use in the US for decades (Hamric, Spross & Hanson, 2005) and, as such, definitions of a CNS in other parts of the world often originate from the US context. The literature defines a CNS as a Registered Nurse who, through both practice and masters level education, has become an expert in a clinical area of nursing (Sparacino, 2005). The American Nurses Association defines the CNS as an, “expert clinician and client advocate in a particular specialty or subspecialty of nursing practice” (1996, p.3).

As with the expert nurse, much of the literature is concerned with characteristics of the CNS role. Hamric, Spross & Hanson (2005) describe several competencies that are said to be integral to the CNS role. These include clinical practice, coaching and guidance, consultation, research, leadership, collaboration and ethical decision making (Sparacino, 2005). There is emphasis on the direct patient care component of the definition, as clinical practice, skills, knowledge and clinical wisdom are said to be the core of CNS practice (Sparacino, 2005).

It is difficult to ignore the NP when looking at CNS’s as they are often compared in the literature. The emergence of the NP and CNS roles in the US was in response to access to quality affordable primary care and highly specialized nursing care for increasingly complex, high acuity, hospital patients (Dunn, 1997). “Thus, nurse practitioners became
There has been much debate in the literature about merging the NP and CNS roles (Gardner, Carryer, Dunn & Gardner, 2004; Elsom, Happell & Manias, 2006), as the roles share many commonalities such as research, education and consulting (Henderson, 2004). The literature, however, suggests fundamental differences in the roles; NPs are, “responsible for diagnosing and managing” and CNSs care for patients with, “already identified health problems” (Gardner et al, 2004, p.11). Dunn, (1997) suggests, in the American setting, a NP provides more comprehensive care than a CNS, but this could be due to the difference in their patient populations. Dunn (1997) states, CNSs generally care for patients in acute hospital settings and NPs are more likely to be in primary health. In New Zealand this is not the case. NPs are registered to work in both acute hospital settings and in primary health and, according to Harris (2007), it appears more are working in acute hospital settings.

In Australia the title CNS refers to a promotional position on a clinical career pathway. There the CNS role was driven by industrial processes and linked to financial progression to, “enable nurses to progress professionally without having to leave the bedside to take up positions in education or…administration” (Elsom, Happell & Manias, 2006, p.57). Yet it appears from the literature that both educative and administrative duties are an integral part of the CNS role in Australia. Duffield et al’s (2005) study found, when examining the roles of RNs and CNSs, that CNSs spent more time engaged in managerial and clerical activities than the RN. This disproportionate amount of indirect care is in contradiction to their defined role and it can be seen in both Duffield et al’s (2005) and Scott’s (1999) studies that role confusion remains an issue for CNSs.

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

Bousfield’s (1997) United Kingdom study is based on phenomenology. Her findings are in accordance with the US literature and describe a very similar picture of the CNS role, “advancing knowledge, expertise and leadership skills” (Bousfield, 1997, p.245). However, Bousfield found CNS’s potential was not being reached as many describe organizational barriers restricting their ability to practice autonomously, as well as feelings of burnout, isolation and role conflict, (1997).

The majority of studies of CNS’s were qualitative and mixed method surveys or phenomenological studies. It appears a major finding of all the studies is that there is still considerable role confusion and ambiguity despite the CNS role having been around in the US for many decades, (Glover et al, 2006, Dunn, 1997, Redekopp, 1997, Scott, 1999, & LaSala et al, 2007). Another recurring conclusion from these studies is that CNSs need to be able to demonstrate the benefits they make to patient outcomes and to prove their role is cost effective (LaSala, 2007, Duffield et al, 2005, & Scott, 1999).

There does not appear to be a clear definition of the CNS role in New Zealand. In 1987 Patterson explored the potential contribution the CNS role could make to the acute setting in New Zealand but there has been little else written about the role from a New Zealand perspective, even though it is clear that the role and title CNS is in use (MECA, 2007). The New Zealand Nurses Organization (NZNO) have a position statement on advanced nursing practice, however this does not specify any role other than the NP. The national PDRP working party report (2005), to the National Nursing Organizations, recommends national role titles. These include advanced clinical titles such as ‘Nurse Specialist’. Since this report, the District Health Boards/NZNO Nursing and Midwifery Multi-employer Collective Agreement (MECA, 2007), expands on role designation and national titles; CNS is included and loosely defined. It states, a CNS has a focus on patient care delivery, provides specialist care and expertise, supports nursing staff to provide expert care, and has a role in research and policy and procedure development (MECA, 2007). The CNS role is further confused by the MECA (2007) which then goes on to define a ‘Specialty Clinical Nurse’. This title appears to involve the same level of
expertise and direct patient care, but stipulates the role has a narrower focus and does not include a research component (MECA, 2007).

Conclusion

This literature review has aimed to explore recent research around the ‘expert nurse’ and CNS titles and roles. It appears there is consensus in the literature that the nursing profession needs to better articulate what is meant by ‘expert’ and advanced practice, and establish some consistency in role titles in order to better direct practice to meet the needs of the patient community. The terms ‘expert’ and ‘CNS’ are often used interchangeably in the literature and it seems there is considerable grey area surrounding advanced practice roles other than the nurse practitioner in New Zealand.

Further research is needed in New Zealand to describe the CNS and other expert nurses in this country, to help define their roles and to highlight the potential and/or actual contribution they make to colleagues, patients and organizations.
Chapter Three

METHODOLOGY

Introduction

This study is classified by its purpose which is an exploratory descriptive case study. An exploratory study, “seeks to explore what is happening and to ask questions about it” (Gray, 2004, p.32). This study aims to provide a picture of the phenomenon studied (Gray, 2004), which in this case is the role of Clinical Nurse Specialist in New Zealand hospitals.

This chapter will explain the methodologies used in the research. The two phases of data collection, document review and semi-structured interviews, and the framework for data analysis will be explained. Limitation and delimitations of the study will be outlined, followed by a discussion of the ethical considerations including anticipation of potential ethical issues of the study.

The CNS Role as a Case Study


Case studies in nursing practice are generally referred to as a reflection on an individual’s illness and treatment. However, in the social sciences, research by case study is widely used in psychology, sociology, anthropology and practice oriented fields such as education and social work and is referred to as an applied social research method (Yin, 1994). A case study in this sense lends itself well to nursing as it is also a practice oriented profession.

Case studies are not widely used in nursing research. This is surprising when examining the definition. A case may be an individual, (such as a patient or a nurse), a group, (nurses or patients), an institution or a community (Gillham, 2000 & Yin, 1994). A case
study is that which investigates the case (as defined above) in order to answer the research question, and which, “seeks a range of different kinds of evidence…which is there in the case setting and which has to be abstracted and collated to get the best possible answers” (Gillham, 2000, p.1).

Polit & Hungler (1995), define a case study as an in depth investigation, where data are generally qualitative and useful where phenomena have not been rigorously researched. They state, “most case studies are non-experimental, in such studies, the researcher obtains a wealth of descriptive information and may examine relationships among different variables or examine trends over time” (Polit & Hungler, 1995, p.200). Berg (2001) defines the case study as, “systematically gathering information about a person, social setting, event or group to permit the researcher to effectively understand how it operates or function” (Berg, 2001, p.225).

Yin defines the case study as an, “inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” (1994, p.13). Case studies explore subjects where relationships may be uncertain. Gray (2004) states the approach is useful when the researcher is, “trying to uncover a relationship between a phenomenon and the context in which it is occurring” (p.124). The intent in this case is to uncover/create a description of the characteristics of the CNS role in contemporary NZ practice. While the CNS role is unique to nursing, the methods of this thesis are not and draw largely on social science perspectives as previously mentioned.

Gray (2004), Yin (1994) and Stake (1995) all explain how the case study approach generally requires data collection from more than one source. “This use of multiple sources of evidence, each with its strengths and weaknesses, is a key characteristic of case study research” (Gillham, 2000, p.2). True to form, this study draws on two sources of evidence. These include data derived from documents describing CNS jobs and data derived from interviews with nurses working in these positions.

This study is sequential in that it was conducted in two separate phases. Phase one is a review of documentation provided by New Zealand District Health Boards describing their CNS jobs. Following this, in phase two the researcher undertook semi-structured
interviews with a purposive convenience sample of CNS’s within the central region of New Zealand. The sequence of the study is significant as the preliminary results of the first phase provided information which allowed the researcher to develop an initial comprehension of the CNS role and helped inform the interview questions in the second phase.

Gray (2004) describes the strengths and weaknesses of both types of data. The strength of documents as data is that they are seen as ‘stable’ evidence that can be reviewed over and over. The process is unobtrusive and exact (Gray, 2004). A weakness, as identified by the researcher, can be the sheer volume of written information requiring fastidious organization and management. Being in ‘hard copy’ form the documents were at risk of damage or loss. Second copies were made of all the job descriptions to ensure data was not lost.

According to Gray (2004), interviews with knowledgeable informants can provide specific and insightful data. In this case they provided a voice to the documents, a human understanding of the role in action. They provided rich and descriptive data that contributed well to the overall aims of the research. The interview process was both exciting and enriching for the researcher. However, it is acknowledged that interviewer bias may be a weakness of interview data and ideally an, “interviewer is a neutral agent through whom questions and answers are passed…however this ideal is difficult to achieve” (Polit & Hungler, 1995, p.289).

Further weaknesses of interview data may be, poor questioning and response, or reflexivity where the, “interviewee gives what the interviewer wants to hear” (Gray, 2004, p.135). As those interviewed knew the researcher was also a nurse they recognized there was empathy and understanding about what they were asked to describe. The researcher was not, however, in a position of authority hence there was little likelihood of their feeling coerced into answering in any particular way.

**A Qualitative or Quantitative Approach?**

Much nursing research is qualitative; the qualitative paradigm lends itself naturally to the nursing profession as much of the complexities and unique nature of what nurses do are
unquantifiable. “Qualitative research is often described as holistic, that is, concerned with humans and their environment in all of their complexities” (Polit & Hungler, 1995, p.517).

It was initially intended that this research was to be purely qualitative. However it became apparent that in order to comprehensively describe the characteristics of the CNS role in NZ with the data obtained, some quantitative analysis was also desirable. Though the overarching paradigm of this research is qualitative, the quantitative data is used to complement the overall picture.

Quantitative research is described as the “systematic collection of numerical information…and the analysis of that information using statistical procedures” (Polit & Hungler, 1995, p.15). Schneider et al. (2007) state that quantitative research, “refers to studies where the variables of interest are measurable and the results are quantifiable and coded as numerical data” (p.157). For the purposes of this study, data such as the number of DHBs who required a tertiary qualification for the CNS role was useful to measure to help describe the national expectations of the role of the CNS.

**A Mixed Method Approach**

This research, therefore, is simultaneously qualitative and quantitative, or mixed method in approach. Schneider et al (2007) describe mixed method research as, “a means for making research more meaningful, completed and purposeful than is the case when using either a singular qualitative or quantitative approach” (p. 249). Using mixed methods allowed the researcher to more fully engage in a case study of the CNS role and describe all aspects of the data. For example, some of the documentation of the job descriptions was best analyzed and presented quantitatively, while it became evident that some qualitative analysis was necessary for other aspects of the data in order to present the most complete description of the CNS role.

Phase one of the research is mixed method in approach. Numerical measures were made of some aspects of the job descriptions and are presented in graph form. Other aspects of the document analysis were treated qualitatively and analysed thematically. Phase two of the research, semi-structured interviews, was entirely qualitative and was also
subjected to thematic analysis. All of the qualitative data analysis was guided by Thomas’s general inductive approach (2003).

**Phase One: A Document Content Analysis of District Health Board CNS Position Descriptions**

The documents collected for analysis were job descriptions of CNS’s from a variety of District Health Boards (DHB’s) in New Zealand in early 2008. The researcher phoned and emailed human resource departments, initially of the central region DHB’s in New Zealand (Hawkes Bay to Wellington), and asked for their most recent CNS job descriptions. The main tertiary centres, Auckland, Waikato, Canterbury and Otago were then approached and asked for the same documents to reflect a New Zealand wide picture.

A total of thirty-two CNS position descriptions were collected. These job descriptions were either a generic CNS job description template or a job description written for a specific specialty position, such as CNS for Diabetes service. Of the total collected fifteen were analyzed in the study, summarized in the following table.

<table>
<thead>
<tr>
<th>District Health Board</th>
<th>Number &amp; type of job descriptions used in study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland DHB</td>
<td>1- generic CNS job description</td>
</tr>
<tr>
<td>Waikato DHB</td>
<td>1- specific CNS job descriptions</td>
</tr>
<tr>
<td>Hawkes Bay DHB</td>
<td>2- specific CNS job descriptions</td>
</tr>
<tr>
<td>Mid-Central DHB</td>
<td>3- specific CNS job descriptions</td>
</tr>
<tr>
<td>Taranaki DHB</td>
<td>1- specific CNS job description</td>
</tr>
<tr>
<td>Wairarapa DHB</td>
<td>3- specific CNS job descriptions</td>
</tr>
<tr>
<td>Capital &amp; Coast DHB</td>
<td>3- specific CNS job descriptions</td>
</tr>
<tr>
<td>Canterbury DHB</td>
<td>1- generic CNS job descriptions</td>
</tr>
</tbody>
</table>

**Table 1: Summary of DHB CNS job descriptions**

Otago DHB is not represented. It was contacted several times but failed to respond. Seventeen documents were excluded from the study either because their titles did not match the exact role under study, for example Clinical Midwife Specialist, Clinical Nurse Leader, Clinical Nurse Coordinator or Specialty Nurse, or because they were repetitive. For example, two DHB’s provided multiple position descriptions that were
for CNSs in different clinical areas. The description of these were the same apart from the work area specified in the job description titles, such as CNS for diabetes services, or CNS for cardiology.

**Phase Two: Semi-Structured Interviews with Clinical Nurse Specialists**

A small purposeful convenience sample of CNSs were invited to participate in semi-structured interviews. The inclusion criteria were Registered Nurses working with the title Clinical Nurse Specialist for a District Health Board in the central region. This was the region for which ethics approval was sought and granted. Excluded from the invitation to be interviewed were nurses without the exact title CNS and/or those working in a maternity setting.

Identifying potential participants was initially difficult. Individual CNSs in the central region DHBs were not known to the researcher by name or specialty and access to names were not given to the researcher by the DHBs. To overcome this, an open letter of invitation to participate in the study was sent to ten CNSs at various central region DHBs (appendix iv). This included information about the research (appendix v), a consent form (appendix vi), an outline of the interview questions (appendix vii) and a return addressed stamped envelope. These were addressed to ‘Clinical Nurse Specialist’ of various specialties. The researcher had identified from the job descriptions in phase one of the research that there should theoretically be a CNS in the specialty in the DHB where invitations were sent.

Of the ten invitations sent six CNSs responded and consented to be interviewed. Of these, four were interviewed, one face to face and three by phone, during a three month period from November 2008 to January 2009. Interviews could not be arranged with the remaining two respondents within this time frame.

Prior to the interviews participants were contacted by phone and/or email to arrange an interview time and to discuss the research project. At this time the participants had the opportunity to ask and have answered any questions about the project, and the researcher ensured that they had a copy of the scheduled interview questions. The interview was semi-structured around twelve main questions (Appendix VII). These were derived from key findings of phase one of the research, the document analysis. All of the participants
chose to write some responses down prior to the interview. Further questions and elaboration on answers flowed through the course of the interviews.

The one face to face interview had the benefit of a greater personal rapport between the interviewer and interviewee. Facial expressions helped guide the interviewer at times to probe certain responses to illicit further information. The three phone interviews did not have the benefit of facial expressions or body language; however tone of voice proved a useful feedback tool.

The interviews took forty-five to sixty minutes to complete. They were audio recorded by two dictaphones and were transcribed by the researcher, this allowed an initial ‘run through’ of the interview data. Notes were also taken by hand during the interviews which served as prompts for unclear recorded words during the transcription process.

The interviews generated rich qualitative data which were analysed using a general inductive approached based on Thomas’s description (2003) which is discussed further in chapter four.

Delimitations of the Study

In phase one of the research, collection of job descriptions was limited to the central region DHBs and the major city DHBs, (Auckland, Waikato, Wellington, Canterbury and Otago). This was to contain the amount of documents for review yet still reflect a New Zealand wide picture. Job descriptions were also delimited to those which had the exact title Clinical Nurse Specialist in order to clearly examine the CNS role. As previously mentioned seventeen documents were excluded from the study as their title did not match the role in question. The interviews in phase two of the study were only extended to the central region of New Zealand in order to qualify for central region ethics committee approval. This was to accelerate and make straightforward the ethics application process in order to meet the time restraints of the study. The time potential participants had to contact the researcher to take part in the study was also restricted to a six week period in late 2008 in order to fit with the study’s time frame.
Limitations of the Study

The elements that were outside the researchers control include both the time frame and size of the study which was determined by the curriculum of the academic institution for which this Masters thesis is intended. The identification of and number of respondents in phase two of the research also was a limitation. The researcher was not able to identify all the CNSs in the central region DHBs, so the invitation to participate was extended to ten random CNSs. There was no control over the number of respondents however six out of ten responses was pleasing.

Ethical considerations

Prior to commencement approval for this study was obtained from the Eastern Institution of Technology (EIT) Faculty of Health and Sport Sciences Academic committee in May, 2008 (appendix i) and from the EIT Research Approvals Committee in June 2008 (appendix ii). With the inclusion of interviews, ethical approval was sought from the Health and Disability Central Regional Ethics Committee in the form of an expedited review. This was granted in September 2008 (appendix iii).

Potential risks of the study were assessed and it was identified that there was minimal risk expected as participants were not in care. Participants were informed volunteers and were not in a dependant relationship with the researcher. There was however a potential risk that interview participants may be identifiable from the work that they describe due to the relatively small number of CNS roles in the central region DHBs. In order to maintain confidentiality, every effort was taken to de-identify data. This was managed by assigning pseudonyms to participants and de-identifying all data from the actual clinical specialty.

Participants were fully informed of any potential risks, were provided with information about the study and given opportunity to question both the researcher and the researcher’s supervisors before taking part in the research. Written informed consent was obtained prior to the interviews commencing.
All confidential materials were kept at the researcher’s home in a locked filing cabinet. Electronic data was stored on the researcher’s private computer and was password protected. The researcher had sole access to all of the participants’ identifying data which will be destroyed at the completion of the study.

**Conclusion**

In this chapter the methodologies for the research has been explained. Explanation and justification for conceiving the research as a case study and using a mixed method approach has been given. The two phases of the research have been detailed. A description has been given regarding the research process, aspects of data collection, sampling, ethical considerations and how the data is to be analysed and presented.
Chapter Four

PHASE ONE: DATA ANALYSIS OF CNS JOB DESCRIPTIONS

Introduction

This chapter will present the results of the analysis of the fifteen CNS job descriptions provided by the DHBs for investigation for this study. All of the job descriptions had similar formatting of the key components and these were broken into four categories for analysis. These categories include:

1.) The statement of purpose of the CNS role.
2.) The qualifications listed as required for the CNS role.
3.) The experience listed as required for the CNS role.
4.) The key performance indicators of the CNS role.

The qualifications and experience listed as required for the CNS role were analyzed quantitatively. The frequency of the types of qualifications and experience listed in the fifteen job descriptions were manually counted. They were then transferred to Excel spreadsheets and expressed in graph forms (see Figures 1 and 2). The statement of purpose of the CNS role and the key performance indicators (KPI) were analyzed qualitatively by a general inductive thematic analysis based on Thomas (2006). The quantitative data is discussed first followed by the qualitative themes.

QUANTITATIVE DATA RESULTS
Qualifications Listed as required for the CNS Role

Of the qualifications listed in the job descriptions provided by the DHBs, the following were considered essential requirements for a CNS and are represented graphically in Figure 1:
Figure 1: Qualifications listed as required for the CNS role

1. **Registered Nurse with current annual practising certificate**:  
   All fifteen (100%) of the job descriptions listed this as an essential qualification. This unanimity is not surprising as it is a legal requirement under the Health Practitioners Competence Assurance Act (HPCAA), (2003) that all practicing nurses must have a current annual practising certificate issued by the Nursing Council of New Zealand.

2. **Holding or working towards a post graduate qualification**:  
   Seven (46.6%) required the CNS to be holding or working towards a post graduate qualification. However, the level of qualification was not specified in any of the job description as being necessarily a certificate, diploma, masters, or doctorate. The type of qualification was also unspecified as needing to be in nursing, management or any other discipline.

3. **Post Graduate Certificate/Diploma in Specialty Nursing**:  
   Two (13.3%) of the job descriptions considered a post graduate certificate or diploma in specialty nursing to be an essential qualification for the CNS role. In total, nine (59.9%) of all of the job descriptions required the CNS to be working towards or holding some form of post graduate qualification. Surprisingly, four (26.6%) of the job descriptions made no mention of any post graduate qualification being required for the CNS role.
4. **New Zealand Drivers’ License:**
Four job descriptions (26.6%) listed a New Zealand drivers’ license as an essential qualification for a CNS.

5. **Computer Literacy:**
Three (20%) listed computer literacy as an essential qualification for the CNS role. The level of literacy required, or competence in any specific computer programme or software, were not specified. The researcher does not consider computer literacy to be a qualification as such, unless a specific computer qualification is requested. It is considered to be more of a skill or area in which one may have variable amounts of experience.

6. **Holding or Working Towards Level Four on a Professional Development Recognition Programme (PDRP):**
Two (13.3%) considered that the CNS should be at or working towards level four (expert nurse) on a Professional Development Recognition Programme (PDRP). It is interesting that this is considered to be an essential qualification for the CNS role as participation in a PDRP is a voluntary exercise. It is not a legal requirement of the nursing council for nurses to take part in PDRP’s.

Two further qualifications were listed in the job descriptions. These qualifications were considered desirable for the CNS role:

1. **Adult or Clinical Teaching Qualification:**
Two (13.3%) expressed an adult or clinical teaching qualification as being a desirable qualification for the CNS role. The level of this qualification was unspecified.

2. **Holding or Working Towards a Clinical Masters:**
Three (20%) of the CNS job descriptions stated that it was desirable that the CNS held or was working towards a ‘clinical masters’.

Figure 1, Qualifications listed as required for the CNS role, also shows that there were four job descriptions that did not mention a post graduate qualification as being essential for the CNS role. This is significant because all of the international and national
literature reviewed in this study state that the CNS role requires preparation at the post graduate level. It is surprising, therefore, that four (26.6%) of the New Zealand job descriptions make no mention of what is considered an essential element of the CNS role.

Areas in which experience was listed as required for the CNS Role:

The following categories outline the areas in which experience was listed as required for the CNS role in the job descriptions. The types of experience were in list form in the documents and the frequency of their occurrence in each job description was collated. The results are described below and presented in graph form in Figure 2 in order of their frequency.

Figure 2: Areas in which experience was listed as being required for CNS positions

1. Clinical experience in the specialty area:
   All fifteen (100%) of the job descriptions required clinical experience in the specialty area. The length of time of experience in the specialty area was unspecified.

2. Teaching, mentoring and preceptorship:
   Thirteen (86.6%) mentioned qualities that referred to teaching, mentoring or preceptorship roles.
3. **Leadership:**
   Ten (66.6%) specified experience in leadership as necessary for the CNS role.

4. **Research and clinical audit:**
   Seven (46.6%) stated experience in research and clinical audit were required for the CNS role.

5. **Quality improvement:**
   Seven (46.6%) of the job descriptions listed experience in quality improvement as required for the role.

6. **Level four on the Professional Development Recognition Programme (PDRP):**
   Six (40%) of the job descriptions desired the CNS to have experience at the level four, ‘expert Registered Nurse’ category.

7. **Being a change agent:**
   Six (40%) of the documents listed experience in being a change agent was required for the CNS role.

8. **Project management:**
   Six (40%) of the job descriptions listed experience in project management as being required for the CNS role.

9. **Autonomous practice:**
   Four (26.6%) listed that the CNS should have experience with practicing autonomously.

10. **Expert clinical assessment skills:**
    Four (26.6%) of the job descriptions listed expert clinical assessment skills as required experience for the CNS role.

11. **Clinical role modelling/motivating:**
    Three (20%) of the job description analyzed listed experience in clinical role modelling and motivating were required for the role.
12. Policy development:

Only one (6%) mentioned policy development as an area where the CNS should be experienced.

Amongst the job descriptions it appears that the areas in which the CNS should have experience for the role are rather varied. It can be concluded that specialty clinical experience, teaching/mentoring/coaching and leadership experience are common areas in which the CNS is expected to be experienced. There are however several other key areas listed which 40-46.6% of the job descriptions listed as important such as research, quality improvement and project management. Overall the job descriptions listed a broad range of experience areas for the role which presents an inconsistent description of the qualities required for the CNS.

QUALITATIVE DATA RESULTS

Purpose and key indicators of the CNS role

Thematic analysis was utilized to evaluate the qualitative data relating to the areas of where the job documentation referred to the purpose and key indicators of the CNS role. The framework for the qualitative data analysis is guided by the general inductive approach described by Thomas, (2006). “The primary purpose of the inductive approach is to allow research findings to emerge from the frequent, dominant or significant themes inherent in the raw data” (Thomas, 2006, p.2). This framework provided a systematic method for analyzing the data.

The two components of the CNS job descriptions that were analyzed qualitatively include the ‘statement of purpose of the role’ and the ‘key performance indicators’. The statements of purpose of the CNS role were one to two paragraph descriptions at the beginning of each job description. The key performance indictors were more elaborate, one to two page lists of the expected CNS’s functional day to day role. Both were analyzed thematically, following close and repeated reading of the text which was scanned for recurrent descriptive words (Thomas, 2006). Lists were made of these recurring words and they were eventually categorically grouped into eight broad themes. This was further broken down to six and then finally four main themes. Thomas (2006)
states that inductive research studies should report between three to eight main themes or categories in the findings.

The four themes that emerged from the analysis of the job descriptions were:

The CNS as

- Leader
- Clinical expert
- Coordinator
- Educator

These will be discussed in turn.

**The CNS as a leader**

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

“To promote excellence in nursing practice” (Taranaki DHB).

“To provide leadership and development of the … team, to coordinate and lead” (Capital & Coast DHB, 2).

“To coordinate and manage the referral, consultation, assessment, management and supervision of nursing staff…role modelling best practice, training and education” (Capital & Coast DHB 3)

Some job descriptions described aspects of leadership as evident through providing expert care. For example, Mid-Central DHB (1 & 2) specified,

“The CNS functions within the specialty providing clinical expertise and leadership that ensures services to clients are provided in the most effective and efficient way”.

Similarly, Mid-Central DHB (3) stated,

“The CNS will act in the roles of a practitioner, educator, consultant, researcher, change agent and leader in the pursuit of clinical excellence and improved health outcomes”
Other comments included:
“The CNS role models quality nursing practice” (Mid-Central DHB, 3).
“The CNS works within a clinical specialty in the capacity of role model, clinical expert, case manager, change agent, educator researcher and leader” (Wairarapa DHB, 1, 2 & 3).

Canterbury DHB state, “The CNS is the acknowledged nursing leader within the hospital clinical specialty”. This clearly implies the CNS role is one of leadership, but it also implies the CNS role is the sole leadership role within the specialty. It does not acknowledge other nursing leaders within the specialty with whom the CNS may work, such as the Clinical Nurse Manager or Clinical Nurse Educator. This statement implies the CNS role leads all other nurses within the specialty.

Auckland DHB describe the CNS as a leader as a, “senior nurse” and as “an advanced nursing practice role”. This is in line with the DHB/NZNO MECA which outlines recommended national senior nurse titles including the CNS (NZNO, 2007).

As indicated in the NZDHB job descriptions, leadership was a clear expectation of the CNS role. This was expressed through role-modelling best practice, maintaining a high standard of professional development and as the acknowledged leader of the specialty area.

**The CNS as a clinical expert**

The CNS is described as a specialist who has specialized expert clinical nursing knowledge and uses this to provide both direct and indirect patient care. Direct care is care provided by the CNS directly for the patient. Indirect care is care that is not provided directly by the CNS but is facilitated or directed by the CNS and provided to the patient by another RN or health provider.

It is unclear in the documents how expertise or specialist knowledge is measured by DHBs although 26.6% of the job descriptions listed expert clinical assessment skills as essential experience for the CNS role. Expertise, in the form of being at, or working towards, level four (expert) on the PDRP is listed as an ‘essential qualification’ in 13.3% of the job descriptions. 40% of the job descriptions list ‘experience’ at level four on the PDRP as required.
Although it is unclear what constitutes expert clinical practice throughout the job descriptions, all of them state that the CNS role is that of a clinical expert. The following two extracts provide examples of this theme:

“The CNS works within a clinical specialty in capacity of clinical expert” (Wairarapa DHB, 1, 2 & 3);

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

Waikato DHB describe the role of the CNS is to, “provide clinical expertise in assessment, treatment, advice, supervision and education”. Mid-Central DHB echoes this in the statement, “The role requires an advanced skill level and theoretical knowledge in a specialized area of practice”.

Hawke’s Bay DHB provides a description of the purpose of the CNS position: “The focus is on care delivery, providing specialist nursing care and expertise, both in direct care delivery and in support to other staff and community providers in the management of a defined patient group.”

Frequently the words expert and specialist are used interchangeably. For example, Capital and Coast DHB outline, “The CNS will provide direct specialist nursing support and expertise for…patients,” and “The CNS is an expert in the care of patients and is primarily responsible for providing direct expert care”, and the CNS has, “specialized knowledge and skills” (Capital & Coast DHB1, 2 & 3).

It is unanimously agreed in the job descriptions that clinical expertise is an essential component of the CNS role. Clinical expertise was described in the job descriptions as specialty skills in care delivery, level four on the PDRP and as expert advice to other health professionals. There are, however, inconsistencies in how expertise is measured which is an issue examined further in phase two of the research.

**The CNS as a coordinator**

The third theme describes the CNS as a coordinator of both the specialty service and patient care. Initially it was thought that coordination was a sub theme within leadership,
however on further analysis it became clear that the role of coordination was distinct from leadership in that it focused solely on coordination of patient care and the specialty service.

The following examples illustrate how the DHBs see the CNS as being a coordinator: “The CNS works within the hospital setting and throughout the…district to coordinate care. The CNS has a key focus on the coordination of the patient journey” (Mid-Central DHB, 1).

The CNS is, “responsible for coordinating and providing specialty primary and secondary assessment, prevention, education and intervention” (Canterbury DHB). Similarly, Auckland DHB state the CNS is, “responsible for providing specialist nursing care and or coordination of care to a specific patient population”.

Coordination of the specialist service was illustrated by Waikato DHB as being, “To coordinate an effective and efficient service, to network, integrate and coordinate the CHD/community interface”. Capital & Coast DHB also state the CNS role is, “to coordinate and lead”, and, “to coordinate the referral of patients to the service”.

There is an obvious expectation in the job descriptions that the role of CNS is one involving coordination of actual patient care and delivery of that care. Similarly the CNS role extends to coordination of the overall specialty service.

**The CNS as an educator**

The final theme to emerge from the analysis of the job descriptions was the CNS as an educator. The education role was extended to patients and their families, to nurses and to other health professionals. This educator role was described as being both formal and informal.

Education to patients and their families was an expectation described in the documents from both Canterbury and Waikato DHBs. These included:

The CNS functions as a, “resource person, responsible for coordinating and providing education for a defined patient population” (Canterbury DHB), and, the CNS role is, “to provide or assist in the clinical education needs of patients/carers…to provide education” (Waikato DHB).
The CNS role as an educator to other nurses and health professionals was described as follows:

“The CNS has a key focus on the education of patients and health professionals through facilitation of both formal and informal learning opportunities” (Mid-Central DHB, 1 & 2). Also, “The CNS provides consultation, support and education for nursing staff”, and, “actively participate in the development of protocols/policies and guidelines” (Capital & Coast DHB, 2). “The role involves the identification of staff training needs and provision of education sessions that address these needs” (Taranaki DHB).

Education is a major theme of the CNS role which is reflected in the descriptions and Key Performance Indicators (KPI) of the role, and 86.6% of the job descriptions listed experience in teaching/mentoring/preceptorship as desired (Figure 2). However, a formal qualification in adult education was not a major feature in the requirements for the role with only 13.3% listing a qualification in adult education as desirable (Figure 1).

Providing education was a clear component of the CNS role. The job descriptions outlined the CNS was responsible for providing education to patients and families as well as to other RNs and health professionals. This included formal teaching sessions, policy development and mentoring of staff.

**Conclusions of the findings of Phase One**

This chapter has presented the results of the data analysis from phase one of the research. Phase one involved a content analysis of documents which were CNS job descriptions from New Zealand DHBs. The only areas in which there was unanimous agreement were the requirements for the CNS to be a NZ RN with a current annual practicing certificate and experience in the specialty area.

Excerpts from the job descriptions were cited to illustrate these themes. The results of the document analysis, specifically the inconsistencies shown in the quantitative results, generated further questions about the CNS role. These findings lead to focused questions being formulated for the interviews in phase two of the study, which were
undertaken with the view to seek clarification and expand on the description of the CNS role from those practicing in it.
Chapter Five

PHASE TWO: DATA ANALYSIS OF INTERVIEWS WITH CNSs

Introduction

This chapter will present the findings of phase two of the research, the semi-structured interviews with four CNSs at central region DHBs in New Zealand. The four interviews for this study were audio recorded and transcribed verbatim. The schedule of semi-structured interview questions were based on the findings from the phase one document analysis in the previous chapter. The interview questions were piloted with a CNS not included in this study to ensure the questions were logical and had good flow. The interviews were intended to give a voice to the job descriptions, to describe the CNS role in action. Participants were asked to describe their role and day to day work. Subsequently, they were asked to give comment on the qualitative themes that arose from phase one, and were asked if they felt these were accurate and complete. Some inconsistent areas in the job description analysis lead to specific interview questions around qualifications, PDRP and expertise. Additionally the CNSs were asked to give an example of how their care differed to that provided by a RN who was not a CNS.

The interviews were fully transcribed by the researcher. This formed a deeper familiarity with the data. Notes were also made by hand during the interviews which served as prompts for any unclear words on the recordings. The transcripts were then read through several times, scanning for repetitive words, or recurring themes.

The data was treated qualitatively and underwent a thematic analysis based on Thomas’s general inductive approach as outlined in the previous chapter (2006). The coding process consisted of key words and passages of text being identified and highlighted. Notes were made in the margins of the transcripts listing possible themes that correlated with the highlighted text. One coded transcript was examined by the supervisors of this research to verify an accurate and complete analysis of the transcript and subsequent themes. Following this process, lists were compiled on large pieces of paper. Words and text examples were grouped in themed categories, forming a loose
flow chart. This allowed a visual representation for the researcher to view the possible themes, subthemes, areas of overlap and interrelation to emerge. From this first chart, two further charts eventuated after more extensive analysis.

From the analysis of the interview transcripts, five main themes emerged as being important issues described by CNSs.

These five themes include:

• The CNS as a leader and the driving force of the specialty
• The CNS as an autonomous expert providing direct and indirect care
• The CNS as a collaborator with integral relationships
• Sharing expertise
• Extending; Time and care

These themes will be discussed in turn. In reporting the experiences and perceptions of the CNSs interviewed, pseudonyms have been given to protect their anonymity.

Further issues were raised by the interview participants when questioned about challenges to the CNS role, PDRP, ongoing education and rates of pay. These will also be discussed.

**The CNS as a leader: The driving force of the specialty**

It became apparent fairly early on in the analysis that leadership was a major theme to emerge from the interviews. Leadership as a component of the CNS role was expressed in two ways:

• Leadership in the drive and development of the CNS role
• Leadership through recognized expert practice and direction of the specialty team

**Leadership in the drive and development of the CNS role**

It was apparent that the CNSs interviewed had, to some extent, to forge or ‘pioneer’ the development of the CNS role. For example, Susan explained,

*I’ve had the role since 2003, so I’m going into the seventh year and I think I have been informally fulfilling many parts of the role as an extension of my role as an*
RN... So eventually I presented a business case for the position, there were no CNS's here yet.

When asked if she was inspired to present that business case by someone else she had met in a role, Susan replied,

No, it was purely my own innovation, I can’t remember who told me I had to present a business case if I had any chance of doing it, so basically I had to present them [management] a business case (laughs), it was pretty grass roots.

Anne described aspects of her involvement in the development of her present CNS role:

...at that time, NZNO and DHB NZ set up a working party to look at job titles and they wanted to standardize job titles around New Zealand and that's when the CNS role came about.

Interviewer: So your role and the working party sort of coincided?

Yes it did. Yes that and the senior nurses MECA was coming in, and at the time all our positions had to be scoped. And we’ve always written our own job descriptions, so what we did was, wrote our job descriptions, at that stage we had a much more strategic position and our manager at the time had a strong belief that senior nurses should be involved in strategic development and clinical planning and all that sort of thing, we had a much more strategic role, so our positions came back as CNS and we were all called that.

The need to drive the role themselves was not limited to its establishment. Emma described this as an on-going process. For example, she said “Sometimes I feel like there's not a lot of support for the role from planning and funding and I’ve got to really drive it” She detailed the wider professional involvement she undertakes as a CNS,

We get quite a lot of ad hoc stuff that comes along, like I’m in the Ministry of Health quality improvement group so that takes up a bit of time. And I’m on the New Zealand guidelines group for [specialty] as well.

It appears the leadership aspect of the role encompasses both the development of the role, as both Susan and Anne described, and wider professional involvement at a national level as Emma stated.

**Leadership through recognized expert practice and the direction of the specialty team**

Some overlap exists between leadership through expert practice and the theme to be later discussed, the CNS as autonomous expert. Further examples of expertise will be discussed in subsequent themes, however, examples given here depict the ways in which CNSs specifically provide leadership through their expertise. For example, Emma
described a typical day of clinic assessments. Her description details a level of practice that demonstrates a high degree of expertise and leadership. She said:

...what I decided...was to actually work with the practice nurses and see patients through them. So I sit in, I do the assessments with them so as they can do it now, and I just make suggestions and then we alter medications, and I inform the GP, what was done and why, and then they do the script. Or, I’m happy, sometimes the GP sits in and I’ll do the assessment with the patients and get the bits and pieces and say, “hey it looks like you probably need this” you know, and sort of direct the whole thing really.

John described his leadership relationship with other staff in his work area:

Sometimes I’m described as the face of the clinical nurse leaders, as in out of the clinical nurse leaders I’m supposed to be the expert...(laughs), I’m supposed to know...Certainly the way the unit sees me, I mean the Charge Nurse Manager runs the unit, he ensures people get paid, that there’s staff, and he even says himself, if there’s any professional issues that need to be dealt with then that always comes towards me. So I sort of lead the professional side of the unit.

John went on to describe how he provides direction through role modelling:

I tend to work Monday to Friday, but I get on the floor at least every day for at least an hour even just to chat to the staff, see how they are, see what’s happening, gauge morale, see if people have got any issues, stuff like that. I think it’s important that you have some visibility; the last thing I would want is for people to think I was stuck in my office all day... and not actually providing any kind of direction.

All four of the CNSs interviewed described ways that they provide leadership in their roles. This leadership came by direction of the team, role-modelling expert practice working along-side GPs and nurses, or simply through providing presence as John described.

The CNS as autonomous expert providing direct and indirect patient care

Much of the literature, as well as the CNS job descriptions analysed in phase one of this research, describe the CNS as an expert. This research looks toward Benner, (1984) who defined ‘expertise’ in the nursing context as a blend of practical and theoretical knowledge found in prior experiences (Benner, 1984). Benner explains that expertise, “develops through a process of comparing whole similar and dissimilar clinical situations with one another, so an expert has a deep background understanding of clinical situations based upon many past paradigms” (1984, p. 294). Thus, expert nurses have, “extensive,
varied, and complex knowledge networks that can be activated to help them understand clinical situations and events” (Hamrie, Spross & Hanson, 200, p.155).

The CNSs interviewed were asked to give an example of the kind of care they provide. Many of the examples given were of the kind of care which qualifies as expert. In fact it was difficult for the researcher to choose which of the many examples to include in the analysis, as they were all particularly rich and descriptive. From the examples given, expert care has been broken down into two further sub-themes:

- Expert direct patient care, such as care given directly to the patient by the CNS.
- Expert indirect patient care, care provided indirectly, where the CNS directs or supports another nurse or health care provider to provide expert care under the CNS’s direction or supervision.

**Expert direct patient care**

When asked to provide an example of the kind of care she provided, Anne described the beginning of her relationship with a new patient:

> I try and contact the women before the clinic, so they know there’s someone there to help them navigate the service for them; they know there’s someone they can ring if they’re worried, because the anxiety for waiting for the appointment is just as high as waiting for the result. So part of my role is trying to allay that fear. I then meet them before the surgeon does, and I take a full history so that’s there when the surgeon does come in and talks to them, so I’ve already become the patient advocate if you like and the patient support person.

Anne also described some of her clinical practice which illustrated an expanded scope of practice:

> One of the complications is a build up of fluid, and what used to happen is they had to go to their GP or come into clinic to drain it, so I actually drain it, just pop a needle in and drain it and that’s part of my expanded role, or my expert role, because I have been overseen and signed off by the surgeon on that. I go in and do that in their homes, particularly over the holidays when there’s no doc around.

All the interview participants were asked what aspects of their care they saw as different to that of the RN. Some of their responses illustrate the expertise required of a CNS. The following are examples:

> “I think it’s that ‘making a difference’, that’s what I see being in this role, you know someone who’s a good CNS makes a difference and can read ahead what the likely issues are” (Emma).
The fact that we use evidence based research and are able to apply that I think that’s the defining one between CNS and RN. The fact that we assess patients, I don’t see a lot of assessing going on in the ward, they might assess a wound, but not a comprehensive patient assessment (Anne).

Susan discussed what she saw as different in her practice to the RN, “I think my assessment is different to what I would expect an RN to do, in-depth planning and evaluation also”. Similarly Emma described how she viewed her practice as differing to the RN, “I think part differs in that you’re more holistic in your thinking, and you’re thinking ahead more”.

**Expert indirect patient care**

The CNSs interviewed describe how their expertise is used to support or guide others in providing expert patient care. Susan said, “I’m really there to advise and assist, so at times I don’t actually administer the treatment”.

They recognized that their role as a CNS was partly focused on setting up an environment for best practice, as John describes,

> The role is very focused on the standards of care within the unit so I look at policies and evidence at what’s going on elsewhere to ensure we deliver the best nursing care we can...I like to think the role modelling aspect of my job helps me to provide expert care, such as you work in a certain way and people see that and hopefully they’re thinking they can do that.

The CNSs described rich and varied examples of their clinical practice which collectively have been categorized as autonomous expert direct and indirect patient care. Like Benner, (1984) and more contemporarily, Hamric, Spross and Hanson’s, (2005) description of expertise, the CNSs interviewed in this study display expert characteristics.

**The CNS as a collaborator with integral relationships**

It is clear in the analysis of the transcripts that the CNS’s expert practice does not take place in isolation. The CNS works as part of a multi-disciplinary team and works both within the hospital environment and out in the community. Thus the CNS must collaborate in order to provide a comprehensive service as the collaborative relationships the CNS has are integral to meeting patient needs. Emma explained:
Quite a lot of what I see is at a very high level, so if I see someone I’ll talk directly to the consultant about it, so it kind of bridges that gap between primary and secondary care. It’s a great role…I work as part of quite a big multi-disciplinary team. Everyone in the team is slightly specialized.

The multi-disciplinary team was an important part of the CNS role. John discussed his role in the meetings as pivotal,

I run a multi-disciplinary team meeting each week and that involves physio, speech language therapy, I have a lot of relationships with allied health people within the DHB, dietician…I’m probably their point of contact as far as changes that we want to make with therapy, that’s my job to liaise…I liaise a lot with the ward, there’s been quite a few changes in the surgery and stuff, changes in how we deliver the care and how we interact with that ward and I’m always quite involved with that.

Similarly Anne played an integral part in the multi-disciplinary team,

I think the biggest part of my role in the multi-disciplinary approach to care. I go to that meeting with all the paperwork that’s required, I allocate them a surgeon and I get them an out patients appointment. So it’s about the coordination of that.

Interviewer: So can I just clarify, did you set up the multi-disciplinary meetings?
It was going in a loose form and I formalized it and got it going better.
I also coordinate referrals and make sure they get off to the district nurses and I make sure they are referred to the social worker if need be, or other support systems.

It is apparent in the analysis that the CNS did not function in isolation. The CNS role involved collaborating with other nurses and health professional in particular with a multi-disciplinary team in formal meetings, which in some cases the CNS managed. These integral relationships were paramount in assisting the CNS to deliver comprehensive care.

Sharing expertise

Some overlap of themes became apparent in the analysis of the interviews. Examples of leadership through expert practice and collaborating with integral relationships also represent ways in which the CNS shares expertise.

This theme’s focal point is on the specific ways in which the CNS shares her/his expertise through education. Sharing expertise outlines the role of the CNS in educating patients and their families, and nurses and other health professionals in both formal and informal ways.
Emma described sharing her expertise in community clinics,

*I feel I am more beneficial working with practice nurses and GPs cause I feel if I’m seeing people on my own, I may only see x amount of people a week, but if I work with five GPs and practice nurses and they work more effectively and that takes it round more people.*

Anne saw herself as a resource for others. She explained,

“I guess I’m a resource person, GPs will ring me for advice, nurses will ring me, patients will ring me with problems…just following up loose ends, trouble-shooter is maybe a good word”.

Many CNSs were involved with formal education sessions as described by Emma,

*I do quite a lot of teaching. We run four day [specialty] workshops. And I do some other teaching. I work with GPs and I’ve also organized some junior GPs to come to clinic and work a few weeks with us as well… ‘I do teaching session on the ward and in the community once a month.*

John was also involved with education and shared the role with the Clinical Nurse Educator in his specialty. He explained,

*I’ve got a really close relationship with the educator. She works a lot with the new staff, does preceptoring and we have a middle merger of both our jobs, so if she’s particularly busy I’ll put myself more on the education side. I teach on std days and stuff like that, that’s just part of the job”. He also assisted with RN’s PDRP preparation, “I help with the progression of the nurses on the PDRP, just give advice and direction.*

Susan was responsible for coordinating the education of RNs related to her specialty area. She said, “I do all the study days, yes that’s a big part of my role, but it’s only me!”

Education was a clear theme to emerge regarding the CNS role. This study believes this is more accurately described as sharing expertise. All of the interview participants gave examples of how they share their knowledge in both formal and informal ways to both patients and other health professionals.

**Extending time and care**

This final theme emerged from a deeper analysis of the interview data. There appeared to be a recurring description of examples of care that were exceptional, examples of extended care or advanced nursing practice. Within this theme there was also evidence
that CNSs extended their commitment to the job, often beyond work hours and into their personal time. Consequently, the fifth theme, extending; time and care, was created.

**Extending care**

Many of the examples the interviewed CNSs gave of their caring roles can not be cited in full here as this may identify their specialty and compromise their anonymity. However the following excerpts provide examples of how the CNS role extends care. Emma described one of her patients:

*The other main issue this man had was financial, he couldn’t afford to pick up his medications, so we looked at it, and tidied up his meds ad got him on a blister pack and we made a pact that if he couldn’t afford his meds we would find the funding somewhere in our budget. And we linked him into clinic, so instead of having to get to this appointment and that, we linked him in so we could do it all at once. I think it’s that you know what the issues are cause you’ve seen them lots of times and you then put into place some things to help get over those barriers.*

Some examples of extending care included situations where work that was previously done by doctors was passed on to CNSs, for various reasons. Anne explained:

“I run a nurse-lead clinic for follow ups. One of the reasons the nurse-lead clinic was set up was because the surgeons were so busy and the nurses could do that work”.

Emma added,

“Or, I’m happy, sometimes the GP sits in and I’ll do the assessment with the patients and get the bits and pieces and say hey it looks like you probably need this, you know and sort of direct the whole thing really”. She went on to describe,

*I spend one morning a week in clinic in the hospital and I see patients exactly the same as the registrars and consultants. So when I see somebody I look at the lab tests etc, what the likely issues are, and I adjust medications, and say they’ve got high cholesterol and they’re not on a statin I’ll speak to one of the doctors and get a script for that.*

It was clear from the descriptions that each CNS provided care that was extensive, comprehensive and at times complex. It is described in the research as both extended and advanced practice.

**Extending time**

The time CNSs dedicate to their role is often also extended. All of the interview participants detailed how their role required more time than they perhaps thought it
should. They all gave examples of how their professional roles crept into personal time, for example, Emma said:

I find I work more than forty hours a week and that’s where the problem comes in with the expectation to do extra study because there’s no time, you don’t get paid for overtime.

Susan also added, “I work a forty hour week, but if there’s any issues I nip out at lunchtime to see someone, so I’m quite busy”.

Anne described working in two roles initially, “They advertised and I was appointed but had to wait until they got a replacement for my job. I actually did a dual role until the end of September, it was huge”.

Emma said her commitment to her patients came before her own professional development needs, “I don’t find I manage my professional development very well because if a patient needs to be seen I’ll go and see them; do you know what I mean?”

Emma also found the demands of the job were such that she ended up working longer hours than she wished. She said,

It’s interesting because I probably wouldn’t have applied for this role if I had been working in [specialty], because it’s full time...but I was so bored in my other role and I missed working as a nurse specialist. But many times I’ve thought, ‘why am I doing this’? Cause I really didn’t want to be full time.

The picture of the CNS role to emerge unanimously involved a dedicated commitment of time, often extending longer than the working week and into individuals personal time.

Additional Findings

Although the five main themes discussed above were the dominant issues to emerge from the interviews, other themes arose which play an important part in describing the CNS’s role. Specific questions were asked regarding what, if any, challenges the CNSs faced in their role. Additional questions regarding whether the CNS was undertaking or considering undertaking further education or participating in a PDRP were asked. Responses to these questions will now be discussed.

Challenges to the CNS role

The CNSs interviewed described two main challenges in their role. The first concerned problems with how the CNS role was viewed by other RNs and GPs. All of the
participants described a negative view or misunderstanding about the CNS role held by other health professionals. When asked about challenges in the role, Anne responded:

*I think one of the biggest things is the lack of knowledge to the role, they are invisible roles. I think there’s a lot of GPs out there that don’t know what we do, we sent out letters, and the GPs didn’t answer, because they didn’t know who the person/role was, because the CNS title was on the letter.*

Anne went on to explain this was not isolated to the GPs she worked with. She said she also met challenges from RNs she encountered,

“A lack of recognition from other nurses about expert roles. I’ve found when I’ve been doing a clinic I was expected to sit in this tiny office with the computer under the curtain. The nurses weren’t prepared to help”.

For John, this challenge came from how the role had been previously perceived. He explained:

*Some of the other people that were in this role, I don’t think did it how it was necessarily expected, so I think particularly with the nursing staff: feeling I am still one of them, still able to do my job and still feel like they’re supported. One or two people that did the job before spent more time out in the office and weren’t so visible. Consequently it’s been a bit of a challenge to turn that round.*

Emma found other RNs she worked with also had negative attitudes to her role,

*There was a little bit of, what’s the word, antagonism isn’t the right word, but there was a little bit of, who do I think I am and why am I any better than the others, but now I’ve done a little more reading, and role ambiguity, its kind of what it is.*

Susan echoes this when she said, “Certainly even some of the RNs can be barriers, they don’t automatically have to accept you in you role”.

The second challenge clearly articulated by the CNSs interviewed concerned the unclear pathway to becoming a CNS and how the role development was unclear. Anne compared this problem with other advanced practice roles. She said,

*It seems now there’s a clear path for the CNS to travel up to Nurse Practitioner but there doesn’t seem to be anything from the ward nurse to the CNS. I don’t see anyone putting up their hands and I think that if we perhaps develop CNS roles there would be a pathway to my job... I think what we need to be doing now is putting some time into developing the specialty roles so that there is now a pathway for CNS. When I go on leave there’s no one to do my role and I think that’s a real fault.*

Emma described how important experience is for the CNS role:
I think sometimes people are put into the role and they haven’t actually got the experience, and I think we need to be really careful about putting people into these roles before they are ready.

Interviewer: Do feel there is a clear pathway for people to become a specialist? No I think it’s all a bit ad hoc, it’s kind of who you are and who you’re working with.

Anne was concerned about not being able to take leave from her role, as there wasn’t anyone to pick up her patient load while she was away:

One of the biggest challenges is that there is no succession planning so there’s no one coming through to do these roles. I have a full patient load...there’s no admin, we do all our own typing, oh I now get someone to type my letters, but the rest is all done by us.

The challenges described by the participants clearly demonstrate both a lack of understanding of the CNS role by other health professionals including other nurses as well as and a lack of a developed pathway to and planning for the role by management.

**Ongoing education and PDRP**

Three out of four of the interview participants were currently undertaking study towards a Master of Nursing degree. All were encouraged by their employers to do so, and were receiving financial assistance for their study fees. The interviewed CNS who was not undertaking Masters Study did not plan to.

John and Emma describe their current MN study,

“So now I’ve started my Masters. It’s a prerequisite for the job. To be absolutely honest I wouldn’t be doing my Masters if I didn’t have to”(John).

“I’m doing my Masters now. I don’t think I would if I hadn’t applied for this job, you know work’s paying for my Masters, so I have to do it or I’d be out of a job”(Emma).

Whereas Anne who was also completing her Masters, stated her motivation to study was more out of personal interest. She said, “I’ve been studying post-grad on and off for years. I’ve always had that interest to study, and as I’ve gone into these roles there’s definitely the drive”.

Two of the four participants were currently at level four, expert, on the PDRP. The other two participants were planning to work towards developing their portfolios to level four.
when they had completed their Masters study. As Emma stated, “I’m not currently on the pathway, I think because I’ve been out of the country and come back and am doing my Masters and I just haven’t looked at the PDRP.

John felt engaging in the PDRP process was important for him as a CNS. He said,

*I think there’s sort of an unwritten expectation that you know, you engage in the process and that you will work your way through. I also think for your own professional accountability, it’s very hard to ask someone else to do that, if you’ve not been through the process yourself.*

Susan was on the PDRP. She said, “As far as I know out of the current CNS’s I’m the only one that’s on the PDRP, you are supposed to you know”.

As the participants described, their differing understandings of whether the PDRP was a mandatory or voluntary requirement for their role remains unclear.

**Conclusions of the findings of phase two**

This chapter has presented the findings of the interviews with CNSs. The interview data was treated qualitatively and underwent a thematic analysis. This generated five themes describing the CNS role. These included leadership, where the CNSs described ways in which they drove the development of aspects of the role as well as leading others through their recognized expertise. The second theme detailed and described CNS expertise. Examples have been given from the interviews of the kinds of expert care these CNS’s deliver in their day to day roles. This was detailed as autonomous expert practice where the CNS provided care directly to patients and families and as indirect care where the CNS’s expertise was used to direct or guide others to provide care.

Collaboration and working in integral relationships was identified as an important theme particularly with reference to how the CNS role is linked to the multi-disciplinary team. This also included the coordination, communication and liaison between other professionals and services in order to provide comprehensive patient care. The fourth theme, sharing expertise, explained the educative role the CNS undertakes. Education is described as the CNS sharing his/her own expert specialty knowledge and experience in both formal and informal ways. Expertise was shared across health care disciplines and to patients and families.
The final theme generated from the interviews was extending time and care. Here the CNSs demonstrated what has been described in the research as an extended commitment to both their patients and their specialty. They described how their professional role crept into their personal time and also how aspects of the care they delivered was extended or advanced.

Additional findings discussed in this chapter came from specific questions regarding PG study and PDRP. The findings showed three of four were current Masters Students and all were encouraged by their employers to engage in PG study for their role. Two of four of the CNSs were on level four, expert on their DHB PDRP. However it was unclear whether this was a mandatory or voluntary process for the role. They also recounted some of the challenges they face which they described as a lack of understanding of their role by nurses and other health professionals, as well as the role requiring commitment of time extending beyond the forty hour working week. From their descriptions it has become apparent that not only are these CNSs practicing in a manner which the literature describes as advanced nursing practice, but that they also very much appear to have forged and defined their own roles thus far.
Chapter Six

DISCUSSION

Introduction

This chapter discusses the findings of the two phases of data analysis of this research. Phase one was a content analysis of CNS job description documents from New Zealand DHB’s. Phase two was a thematic analysis of semi-structured interviews of CNSs. The two major issues to emerge from the data analysis concern expertise and how that is defined, and features of the CNS role related to the themes of extending time and care as presented in chapter five.

The CNS is an expert, but what does that mean?

Endeavouring to describe the CNS role in New Zealand has led to a focus on what constitutes expert nursing practice as the CNS is often referred to as an expert in their field. Comparing the two data sets in this study reveal there are aspects that are consistent and inconsistent about the CNS role.

The consistencies found in both the job descriptions and the interviews describe the CNS role as involving leadership, having an educating role and requiring a level of clinical expertise in the specialty area. Clinical expertise or expert nursing within the specialty appears to be the heart of the CNS role, however what qualifies expertise remains inconsistently defined. The data shows that expertise is measured in a variety of ways, through:

- Post graduate qualifications
- PDRP
- Experience in the specialty
- Who you know and work with

The job descriptions were inconsistent in specifying what level of post graduate (PG) qualification was required for the CNS role. Chapter four details 46.6% of the job descriptions listed some form of PG qualification (or working towards) as necessary for
the role. A PG certificate or diploma was specifically cited as a requirement in 13.3% of the job descriptions. In total 59.9% of the job descriptions listed some form of PG qualification as a necessary requirement for the role. However 26.6% made no mention of any PG qualification being required.

This implies that it is not absolutely necessary to hold a PG qualification for the CNS role in New Zealand. However, international literature and national professional body statements contradicted this. In the 1980’s in the US the CNS was expected to have developed expertise through, “…study and supervised practice at the graduate level (master’s or doctorate)…” (Hamric, Spross & Hanson, 2005, p.417). Currently the ICN (2005) recommends a Masters Degree for entry level for advanced practice nursing roles which includes the CNS. Nationally, the Nurse Executives of New Zealand’s position statement on advanced clinical practice roles states, “A CNS has/is completing a relevant post graduate qualification to prepare for advanced knowledge requirements to undertake specialist practice” (Nurse Executives of New Zealand, 2007, p.2).

In contrast to the data obtained from the job descriptions, the interview data suggests that a Masters qualification is an essential requirement for the CNS role. As John said, “So now I’ve started my Masters. It’s a prerequisite for the job. To be absolutely honest I wouldn’t be doing my Masters if I didn’t have to”. Emma’s thoughts were similar, “I’m doing my Masters now. I don’t think I would if I hadn’t applied for this job, you know works paying for my Masters, so I have to do it or I’d be out of a job”.

All of the CNSs interviewed stated post graduate education was encouraged by their employers. Three of four of the CNSs were current Masters Students. All of the CNSs held PG certificates or diplomas. Anne described her PG education as part of what distinguished her role from other RNs:

"I think the difference between the nurse on the ward and CNS is that we work very much from an evidence based research framework. I think a lot of that’s around the fact that we are expected to do further study and I think that’s where we get the advanced knowledge."

Expertise was also measured through achievement of level four, expert, on DHB PDRPs. Of the job descriptions, 13.3% stated the CNS should be at or working towards level four, expert, and this was listed as an essential qualification. Forty per cent listed level four, expert as an experience requirement for the role. Hawke’s Bay DHB was the only
health board to clearly state that expertise was measured directly through the CNS achieving level four on the PDRP. They state, “Expert clinical practice (is) evaluated through confirmed assessment on PDRP with 100% compliance with evidence of meeting expert level criteria of the nursing PDRP” (appendix vii, Hawke’s Bay DHB 1 & 2).

The interview data suggests that the CNS should also be at level four, expert. However whether this is an essential or voluntary professional development activity remains unclear in the data. John describes this as an unwritten expectation, “I think there’s sort of an unwritten expectation that you know, you engage in the process (PDRP) and that you will work your way through”. Whereas Emma believed the PDRP to be voluntary:

I’m not currently on the pathway, I think because I’ve been out of the country and come back and am doing my Masters and I just haven’t looked at the PDRP. You don’t have to be, it’s not a requirement. But I’ve done a lot of papers and I’ve got a lot of experience and the people that interviewed me knew that.

Susan was on level four on the PDRP and she said, “As far as I know out of the current CNS’s I’m the only one that’s on the PDRP, you are supposed to you know” Anne stated it was compulsory for the CNS role at her DHB. She said, “We are expected to be at level four on the PDRP, you won’t be looked at for these roles if you’re a level three, you won’t be looked at for a CNS position”. The inconsistencies regarding the necessity of the PDRP to the CNS role suggests expertise, then, must be evaluated through other measures as, “nationally there is low participation in the PDRP program and a high level of resistance from some nurses” (College of Nurses Aotearoa, 2009, p.8).

Specialty clinical experience was considered an essential component in the DHB job descriptions. All of the job descriptions analysed in phase one required the CNS to have experience in the clinical specialty. The amount of experience or the length of time for it to be accumulated was not specified. However, other specific areas of clinical experience were detailed in the job descriptions. These included: project management (40% of the job descriptions), autonomous practice experience (26.6%), expert clinical assessment skills (26.6%) and experience with policy development (6%).

Benner’s (1984) seminal research lays the foundation for understanding nursing expertise and skill acquisition, and is the framework for New Zealand’s PDRP. Her work examines the nature of nursing practice and the development of nursing expertise.
Expert practice in the literature is described as being, “characterized by a specific mode of thinking evolved from the merger of knowledge, skill and experience” (Effken, 2001, p. 247). Experience alone does not make an expert, though knowledge is acquired at least in part by immersion in practice (Altmann, 2007). Benner describes this learning as knowledge acquired by the apprentice observing the master (1984).

The literature suggests that determining domains of experience or competencies of advanced practice are essential in articulating the scope of the CNS role (Hamric, Spross & Hanson, 2005). These competencies for advanced practice include:

- direct clinical practice
- expert coaching and guidance
- consultation, research
- clinical and professional leadership
- collaboration
- ethical decision making (Hamric, Spross & Hanson, 2005).

Determining domains of practice or competencies for advanced practice seems the most credible method in validating what experience is necessary for the CNS role, as one nurse may have 20 years experience in a specialty area, but not possess the critical thinking skills or advanced assessment that make the experience useful for advanced practice.

Hickmott, (2007) suggests that nurses in CNS roles nationally may not meet the international or national definitions of advanced practice nurses. She states, “I am aware of some senior nursing staff that have obtained these positions through entitlement, i.e. from years of service within an organization, and not necessarily because of their advanced practice characteristics” (Hickmott, 2007, p. 2). She also suggests that there is little difference between CNS practice and that of RN who has been levelled as expert, level four on a PDRP (Hickmott, 2007). This research does not support that argument.

The DHB/NZNO MECA describes the CNS role as a ‘senior nurse’ and details a higher associated pay scale for the role. Recently, the Ministry of Health hosted a meeting to examine issues relating to extended and advanced practice as well as issues relating to credentialing (College of Nurses Aotearoa, 2009). A key issue raised was the need for, “structure and process for national nursing recognition of standards and specialty
competencies” (College of Nurses Aotearoa, 2009, p.8). The MECA senior nurse description, the characteristics of the CNS role described in this research and the Ministry of Health meeting (2009) highlighting the need for extended and advanced standards and competencies for practice illustrate the CNS role is beyond the present Nursing Council RN scope of practice.

All of the interview participants described rich and varied nursing experience detailing examples of their expert clinical practice. The use of advanced assessment skills, holistic practice, and evidence based practice were all identified as important areas of experience of the CNS role in the data. Emma describes her assessment skills, “We are very autonomous and holistic, you’re aware of peoples living situations, and we do really holistic assessments”. Susan echoes this when she said, “I would think my assessment is more advanced, it’s different to what I would expect an RN to do”.

Anne described the importance of research and how she draws on her PG study for evidenced based practice:

We use evidenced based research and are able to apply it. As I said one of the important characteristics is that we use evidenced based research to practice and I don’t think you can do that if you haven’t done any post grad study.

Who you know and work with also had some bearing on how the CNS’s expertise was judged. This appears to be due to the essential multi-disciplinary team approach, as well as the inconsistency in the articulated requirements for the role. Emma describes how her experience was viewed as more important than obtaining level four on the PDRP. She said, “I just haven’t looked at the PDRP. But you don’t have to be, it’s not a requirement. But I’ve done a lot of papers and I’ve got a lot of experience, and the people that interviewed me knew that”.

Perhaps the inconsistencies in describing CNS expertise stems from how the role has developed in New Zealand. In many ways it appears that the CNS role has been developed and defined by the nurses themselves who are in the roles. Those interviewed described their various personal journeys to the CNS role. All of the CNSs had been in senior or advanced nursing roles prior to their CNS role, either as manager, team leaders or case coordinators. Three of four of the CNSs held those positions overseas. These
prior experiences have contributed to the specialty knowledge they bring to the CNS role.

An additional feature of the CNS interviews is that the participants appear to have largely set themselves on route to the role, as there was not a clear pathway to the role previously. In fact one, Susan, pioneered the CNS role at her DHB:

_I am going into the seventh year and I think I have been informally fulfilling many parts of the role as an extension of my role as an RN...So eventually I presented a business case for the position, there were no CNSs here yet._

This drive and commitment of the CNSs interviewed is evident in the themes ‘A leader the driving force of the specialty’ and ‘Extending time and care’ detailed in chapter five.

The nursing profession can not however, rely on the continued self motivation, commitment and altruism of individual nurses to describe and drive these advanced roles. The absence of a consistent structured description of the CNS role and career pathway to the CNS role has created a certain amount of role ambiguity. Role ambiguity is defined as, “unclear expectations, diffuse responsibilities, uncertainty about sub roles” (Hamric, Spross & Hanson, 2005, p.115). Role ambiguity is not new to the CNS role internationally and is evident in the literature (Redekopp, 1997), however this research suggests it is also a feature of the CNS role in New Zealand. Indeed Emma described the lack of understanding of her role by other RNs as a challenge she faced.

_There was a little bit of, what’s the word, antagonism isn’t the right word, but there was a little bit of, who do I think I am and why am I any better than the others, but now I’ve done a little more reading, and role ambiguity its kind of what it is._

The CNS role appears to have evolved organically as many of the nurses have themselves forged the advanced practice roles. This is perhaps in part why the role remains unclear and inconsistent in New Zealand. The differentiation between the Nurse Practitioner (NP) (the other prominent advanced practice role in New Zealand), and the CNS has also been described as unclear (Hickmott, 2007). Indeed there is debate outside New Zealand as to whether the CNS and NP roles should be merged (Elsom, Happell & Manias, 2006).
The District Health Boards of New Zealand (DHBNZ) states,

The ability for NPs in New Zealand to have narrower scopes of practice and with or without prescribing has made the difference/division between CNS and NP roles less distinct than other countries (DHBNZ, 2008, p.2).

In fact DHBNZ’s outline of the differences between CNS and NP makes little distinction between the roles. They state both CNS and NP work within a specialist population and embody, “extended, expanded and advanced practice” (DHBNZ, 2008, p.2). They also describe that nurse-lead clinics are the domain of NPs not CNSs. However the CNSs interviewed in this research did run nurse-lead clinics.

DHBNZ state, “the NP scope provides a clinical career pathway for those nurses who have attained a Masters degree in nursing (usually clinical) and who are expert, advanced practice nurses” (2008, p.2). This description matches that which has emerged as the scope of the CNSs interviewed in this study; however educational preparation requirements were inconsistent in the job descriptions. The clear differences between the NP and CNS roles then, is that there appears to be a clear path to NP endorsement, and a separate delineated NP scope of practice which may or may not include prescribing rights (and subsequent tighter regulation). This sets the NP apart from all other RNs and indeed other senior nurses, including the CNS, even though the CNS is described also as an advanced practice role.

It is surprising that the CNS role remains so unclear and ill-defined. It is over ten years since the Ministerial Taskforce on Nursing, (1998) identified the importance of advanced practice roles and recommended their development. At that time the taskforce recognized that nursing’s potential was not fully realized due to the fragmented and informal development of advanced and specialist nursing roles. (Ministerial Taskforce on Nursing, 1998). The report specifically discussed the need to define and develop both the NP and CNS roles in New Zealand. Emphasis was placed on the CNS role in particular when they stated,

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

The taskforce also recommended a nationally consistent framework for PG nursing education by tertiary education providers be implemented. This consistency was seen as crucial in facilitating nurses to expand their specialist knowledge. Again there is consistency between the taskforce report, professional nursing body statements on the CNS role, and the views of CNSs interviewed in this study who agree PG education is essential to CNS practice. This is not however consistently reflected in the job descriptions described by DHBs.

The most significant change resulting from the taskforce report was legislative with the implementation of the HPCAA (2003). The consequent change in Nursing Council competency based annual practicing certificates saw the roll out of DHB PDRP’s. However, the act also created the potential for the Nursing Council to create and regulate, “specialist and advanced competencies for practitioners” (Ministerial Taskforce on Nursing, 1998, p.15). While this has indeed occurred with the defined NP scope of practice and separate registration, the CNS role appears less recognized as it shares the same scope of practice as the RN.

The taskforce recommended that the Minister of Health direct the Nursing Council to,

Work with nursing organizations, agencies in health and disabilities services sector, and postgraduate education providers to develop, recognize and validate specialist competencies, within a larger framework, which are linked to nationally consistent titles (Strategy 6, Chapter 2, section 2.5) (Ministerial Taskforce on Nursing, 1998, p.18).

More recently a Ministry of Health meeting between NZNO, College of Nurses Aotearoa and other nurse leaders state the need for clarification of terminology and definition regarding extended, expanded and advanced practice was, “obviously required” (College of Nurses Aotearoa, 2009, p.8). However from this research in can be seen that this has not eventuated for the CNS in New Zealand. While nationally consistent titles have been formalized in the DHB/NZNO MECA (2007) including the CNS title, there has been little focus on delineating the CNS’s scope of practice and competencies within that scope as they still fall under the Nursing Council RN scope of practice. Furthermore, the
inconsistent requirements for the role evident in the job descriptions, particularly regarding post graduate qualifications, fails to clearly articulate the role as an advanced practice role as defined in the literature.

Conclusions

This chapter has presented a discussion of the findings of the research. The discussion has drawn together and compared the two data sets and focused on the consistencies and inconsistencies of the CNS role shown in both. While some consistent aspects of the role have emerged, it has been shown that the inconsistencies continue to present a poorly defined picture of the CNS role in New Zealand. These are mainly concerned with how expertise is measured, specifically in what PG qualifications are necessary for the role and whether or not being levelled ‘expert’ on the PDRP is an essential process for the role.
Chapter Seven

CONCLUSION AND RECOMMENDATIONS

Introduction

This chapter provides a conclusion and summary of the research findings, possible implications for nursing practice and recommendations for future research. The research question sought to describe the characteristics of the CNS role in New Zealand. The aims of the research were:

- To establish what is known about the CNS role in NZ.
- To describe the qualities and characteristics of the CNS role.
- To compare and contrast the NZ CNS role with how the role is described in international literature.
- To contribute to national discussion and knowledge of the CNS role.

To meet these aims a case study of the CNS role was undertaken using mixed methods and analyzing documents and interviews to describe the role in New Zealand.

Chapter two reviewed national and international literature around the expert nurse and CNS title and role. It was established that considerable literature exists related to the CNS role though the majority originates from the US, UK and Australia and relates to the context of those countries. There is however consensus in the literature that the nursing profession needs to better articulate what is meant by ‘expert’ and ‘advanced practice’ and to establish consistency in the CNS role title and scope in order to better direct practice to meet the needs of the patient community.

Little research was found regarding the CNS role in New Zealand. It was established that the CNS role was explored as early as the 1980’s (Patterson, 1987). Some discussion of the CNS exists in New Zealand literature in documents such as The Ministerial Taskforce on Nursing (1998) and professional body statements such as The Nurse Executives New Zealand, (2007). There remains, however, considerable confusion
surrounding advanced practice roles other than the NP in New Zealand and there is a clear gap in national research regarding the CNS role.

This chapter will discuss the summary of the findings from this research in relation to the research aims. The limitations of the study will be discussed and recommendations for nursing practice and future research will be presented.

**Summary of findings**

This research sought to establish what is known about the CNS role in NZ and shown the CNS role is ill-defined, inconsistent and that those practicing in the role are to a large part defining it for themselves.

Phase one of the study found many inconsistencies in the job descriptions provided by DHBs regarding qualifications, PDRP and types of experience required for the CNS role. The qualitative themes from the job descriptions revealed four aspects of the CNS role, which described the CNS as a leader, an expert, a coordinator and an educator.

Phase two investigated the experiences of CNS’s in New Zealand through interviews with four who were practicing in central region district health boards. This generated rich and descriptive data from which five themes emerged. These include the CNS as a leader and driving force of the specialty, an autonomous expert, a collaborator with integral relationships, sharing expertise, and extending in time and care.

The research sought to describe the CNS role in NZ and found the role is characterised by the themes addressed above. By comparison internationally, the role in NZ is lacking in a number of areas, specifically lacking a recognised advanced scope of practice, and a lack of consistently defined qualifications for the role. Finally this research has contributed to national discussion and knowledge of the CNS role by providing information based on research which presents a picture of how the role is carried out and is experienced.

**Limitations**

The limitations of the findings relate to the study’s size. The difficulties in identifying potential interview participants lead to a small sample. This sample was also limited to
the central region to comply with ethical approval. The small sample of interview participants makes it difficult to generalize the findings to represent all New Zealand CNSs working in New Zealand DHB’s. This study also only examined CNS roles within DHB’s so can not be generalized to CNSs working outside of the DHB setting. A larger study would be required to be representative of this study population.

**Recommendations**

The recommendations from this research are two-fold. They are aimed at clearly delineating the CNS role in New Zealand by eliminating the inconsistencies presently associated with the role in New Zealand and recognizing and developing the advanced nursing practice role many CNSs are already undertaking.

The recommendations include the following:

1. Implement nationally consistent role preparation, specifically academic entry requirements. It is recommended that a MN is the minimum requirement to align with international standards.

2. Seek nationally consistent definitions regarding expert practice in relation to the CNS role, including clarification regarding the necessity of PDRP levelling. Develop supervised/guided practice positions for MN students to foster the development of future CNSs.

3. Consider the development of a separate Nursing Council scope of practice for the CNS role, one that is expanded from the RN scope of practice to delineate and acknowledge the advanced practice role the CNS undertakes.

4. Develop supervised/guided practice positions for MN students to foster the development of future CNSs.

5. Recommend further research be undertaken to explore the relationship between CNS practice and patient outcomes including research directly linking cost-effectiveness to these nursing roles. This would both affirm the importance of these roles and may serve to retain and promote advanced practice roles more firmly within the profession and the wider community.
References


College of Nurses Aotearoa. (2009). Nursing collaborates on project to address issues related to professional competency. Te Puawai: The Blossoming. April, 8-11.


APPENDICES

Appendix I  Letter of research approval, Faculty of Health and Sport Science, Eastern Institute of Technology

5 June 2008

Jennifer Roberts
811 Caroline Road
HASTINGS 4122

Dear Jennifer,

Thank you for submitting your research proposal which has now been reviewed by your Principal Supervisor, Dr Shona Thompson. A copy has also been sent to your Associate Supervisor, Sue Floyd.

The Faculty Academic Committee met on Friday 30 May 2008, and has approved your research titled “What are the characteristics of the clinical nurse specialist in New Zealand?”, to progress. Please contact your supervisors to schedule regular meeting times throughout your thesis journey. The first M9.490 Research Progress Discussion is scheduled for 23 June 2008, 9am – 11am, in M116. All supervisors are invited to attend this session. You may wish to consider arranging a meeting with your supervisors later on this day.

Your completed REA 1 Forms and a copy of your proposal was forwarded to the EIT Research Approval Committee which also met on Friday 30 May 2008.

If you have any questions please do not hesitate to contact me.

Yours sincerely,

Rachael Vernon
Head of School, Nursing
For the Faculty Academic Committee
Faculty of Health and Sport Science

Cc: Dr Shona Thompson, Sue Floyd
Dr Susan Jacobs, Marietta Foote
Appendix II Research Approvals Committee letter, Eastern Institute of Technology

HAWKE'S BAY

Ref: 6/08

24 June 2008

Jennifer Roberts
811 Caroline Road
Hastings 4122

Dear Jennifer

Master of Nursing Student Research – Faculty of Health & Sport Science

I apologise for the untimely delay in notifying you that your research project 'Masters Research', was examined by the Research Approvals Committee at their meeting held on 30 May 2008.

I am pleased to advise that the Committee has approved your project.

We wish you well for the project.

Yours sincerely

Jeanette Fifield
Secretary
Research Approvals Committee

Cc: Head of School, Nursing – Faculty of Health & Sport Science

EASTERN INSTITUTE OF TECHNOLOGY
MAIN CAMPUS Gloucester Street, Private Bag 1201, Taumarunui 4141, New Zealand. Telephone 06 974 8000, Facsimile 06 974 8910
Web www.eit.ac.nz Email info@eit.ac.nz
HASTINGS CENTRE Cnr Lyndon & Railway Roads, PO Box 1477, Hastings 4150. Telephone 06 878 4700, Facsimile 06 878 2965
CENTRAL HAWKE'S BAY CENTRE 51 Russell Street, PO Box 230, Waipukurau 4242. Telephone 06 838 7000, Facsimile 06 838 7018
FLASHMERE CENTRE Flashmere Village, Flashmere Road, Flashmere 4120. Telephone 06 974 8915
WAIKOP CENTRE Cnr Paul & Queen Streets, Waikouati 4108. Telephone 06 838 3349
Appendix   III Central Region Ethics Committee approval

20 October 2008

Jennifer Roberts
811 Caroline Road, Hastings, 4122

Dear Jennifer

What are the characteristics of the Clinical Nurse Specialist role in New Zealand? Jennifer Roberts

CEN/08/46/EXP

The above study has been given ethical approval by the Central Regional Ethics Committee.

Approved Documents:
- Schedule of interview questions for the study “What are the characteristics of the Clinical Nurse Specialist Role in New Zealand”, dated 1 October 2008
- Information Sheet, 1 October 2008
- Consent Form, 1 October 2008.

Accreditation
The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Final Report
The study is approved until June 2009. A final report is required at the end of the study and a form to assist with this is available at http://www.ethicscommittees.health.govt.nz. If the study will not be completed as advised, please forward a progress report and an application for extension of ethical approval one month before the above date.

Amendments
It is also a condition of approval that the Committee is advised of any adverse events, if the study does not commence, or the study is altered in any way, including all documentation and advertisements, letters to prospective participants.

Please quote the above ethics committee reference number in all correspondence.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Yours sincerely

S. Scott
Central Regional Ethics Committee Administrator

Email: sonia_scott@moh.govt.nz
Appendix IV Letter of invitation to participate in research

HAWKE'S BAY

November 11 2008

Dear Clinical Nurse Specialists,

My name is Jennifer Roberts and I am a Registered Nurse at Hawkes Bay District Health Board. As the final part of my Master of Nursing degree at the Eastern Institute of Technology (EIT) Hawkes Bay I am completing research about the Clinical Nurse Specialist role in New Zealand.

I am looking for CNSs to participate in interviews about their roles and the work they do. These will be confidential phone interviews around thirty minutes long. I have enclosed a sample of the kinds of questions I may ask and a copy of the research information sheet.

The aim of my study is to establish a picture of the CNS role in New Zealand and how this role is similar and or different to other advanced nursing roles in New Zealand. The overall question of my study is: What are the characteristics of the Clinical Nurse Specialist role in New Zealand?

If you would like to participate in this study or would like further information could you please contact me by phone or email?

Thank you,
Jennifer Roberts
06 870 3704 (home)
021 024 804787 (mobile)
boober_jennifer@yahoo.com.au
Appendix    V    Participant information sheet

What are the characteristics of the Clinical Nurse Specialist role in New Zealand?

INFORMATION SHEET

11 November 2008

Dear Clinical Nurse Specialist

My name is Jennifer Roberts and I am a registered nurse at Hawkes Bay Health Board. As the final part of my Master of Nursing degree at the Eastern Institute of Technology (EIT) Hawkes Bay I am completing research about the Clinical Nurse Specialist (CNS) role in New Zealand.

The aim of the study is to identify the characteristics of the CNS role in New Zealand, through an exploratory case study analysis of District Health Board position descriptions, New Zealand and international literature and interviews with current CNSs. Because of your position as a CNS, and the knowledge and experience you have of that role, you have been invited to take part in this study.

Your participation would involve being interviewed by me, over the telephone, at a time of your convenience. The interview will take approximately thirty minutes. A copy of the interview questions will be provided to you prior to the interview. With your consent the interview will be audio-taped. All information from the interviews will remain confidential, and no information that could identify you will be included in any reports. This study has been approved by the Central Region Ethics Committee and the Eastern Institute of Technology (EIT).

For further information please contact me on 06 8703704 or at: boober_jennifer@yahoo.com.au

I am happy to provide further information about this research or alternatively you may contact my supervisor Dr. Shona Thompson, Faculty of Health and Sport Science, EIT, Hawkes Bay on (06) 974 8000 ext 6116.

Should you require further information regarding your rights you may contact the National Health & Disability Consumer Advocacy service telephone 0800 555 050 or email advocacy@hdc.org.nz

Thank you for taking the time to read this letter and I look forward to hearing from you.

Jennifer Roberts RN
Master of Nursing Candidate, EIT
(06) 870-3704
boober_jennifer@yahoo.com.au
Appendix VI Participant consent form

11 November 2008

CONSENT FORM

Project Title: What are the characteristics of the Clinical Nurse Specialist role in New Zealand?

Researcher: Jennifer Roberts

I have read and I understand the Information for Research Participants sheet dated 11/11/2008 for volunteers taking part in this study. I have had the opportunity to discuss this study and am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time.

I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I have had time to consider whether to take part, and know who to contact if I have any questions about the study.

I agree to take part in this research

Yes ☐ No ☐

I consent to my interview being audio-taped ☐ ☐

I wish to receive a copy of the results ☐ ☐

I would like the researcher to discuss the outcomes of the study with me ☐ ☐

Signed: _______________________________

Name: _______________________________

Signature of Research Participant’s Support Person (if applicable)

Date: _______________________________

Witness: _______________________________

I, the researcher(s) undertake to maintain the confidentiality of information gathered during the course of this research.

Signed: _______________________________

Dated: _______________________________
Appendix VII  Schedule of interview questions

1 October 2008

Schedule of interview questions for the study:

*What are the characteristics of the Clinical Nurse Specialist role in New Zealand?*

**Researcher:** Jennifer Roberts

1). How long have you been in your current role?

2). How did you come to be in your present role as CNS?

3). Can you tell me about your role and the work that you do?

4). Delivering/providing ‘expert nursing care’ is said to be an integral part of the CNS role. Can you give me an example of the patient care that you provide?

5). What aspects of the care that you give do you see as different to the RN?

6). Approximately what percentage of time do you spend delivering patient care?

7). When you aren’t with patients providing care, how else is your role divided?

8). What if any challenges are there to your role as CNS?

9). What do you see as the defining or most important characteristics/qualities of the CNS role?

10). From my findings of the analysis of NZ CNS position descriptions (job descriptions), four themes emerged: The CNS as an expert nurse, a leader, teacher and coordinator.

   a). Could you give comment on my findings/themes?

   b). Do you feel that is an accurate summary of your role?

   c). Is there anything missing from the list?

11). Are you required to be at a certain level on the PDRP?

12). If you don’t object, could you tell me what grade your position is paid at on the NZNO MECA?

   To your knowledge are CNSs paid the same in your DHB or are some graded differently?

13). Could you tell me what your highest academic qualification is in relation to your role?

14). Are you or would you consider undertaking any further study in relation to you role?

15). Is there anything else you can tell me/ I’ve failed to ask about the CNS role?
Appendix VIII List of DHB CNS job descriptions

List of District Health Board Clinical Nurse Specialist job descriptions


Mid-Central District Health Board (2), Vacancy ID: 0985. Position description: Clinical Nurse Specialist: Respiratory services.


Wairarapa District Health Board (2), December 2006. Position description: Clinical Nurse Specialist: Cardiology.


