CLINICAL NURSE SPECIALIST CORE COMPETENCIES

EXECUTIVE SUMMARY 2006-2008

THE NATIONAL CNS COMPETENCY TASK FORCE

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NATIONAL CNS CORE COMPETENCY PROJECT
EXECUTIVE SUMMARY

Introduction

This Executive Summary describes the work of the National CNS (Clinical Nurse Specialist) Competency Task Force (herein called the Task Force), which from 2006 – 2008 identified and validated core CNS competencies and behaviors. This publication provides the listing of competencies and behaviors (see Appendix 5) as well as definitions of terms used in the competency document (see Appendix 4).

The core CNS competencies are comprehensive, entry-level competencies and behaviors expected of graduates of master's and post-master's programs that prepare CNSs. Due to the wide range of specialties in which CNSs practice, these competencies reflect CNS practice across all specialties, populations, and settings. Fundamental to these competencies is that the CNS maintains clinical privileges, certification (when available) and advanced practice recognition according to state and institutional requirements.

It is anticipated that education programs preparing CNSs should not have to make extraordinary curriculum revisions to incorporate these competencies. The NACNS (National Association of Clinical Nurse Specialists) will facilitate a multiorganizational review and update of these competencies every 5 years to ensure the national CNS competencies reflect current and relevant practice based on evidence-based knowledge and societal needs.

Background

In 2006, as the nursing profession moved toward a consensus-based model for a cohesive and collaborative approach to licensure, accreditation, certification, and education of Advanced Practice Registered Nurses, NACNS and the APRN (Advanced Practice Registered Nurse) Consensus Workgroup (see Appendix 1 for a listing of Workgroup member organizations) requested that the ABNS (American Board of Nursing Specialties) and the ANA (American Nurses Association) convene and facilitate the work of a National CNS Competency Task Force, using the *National Consensus-Building Process to Develop Nationally Recognized Education Standards and Role/Specialty Competencies*(see Appendix 2), identified by the APRN Consensus Workgroup in its early work together.

Representatives from CNS stakeholder groups were convened in May, 2006 by facilitators Bonnie Niebuhr, MS, RN, CAE, ABNS CEO and Mary Jane Schumann, MSN, RN, MBA, CPNP, ANA's Chief Programs Officer, to participate in a national project to identify, validate and achieve consensus on *core* CNS competencies relevant to the entry-level CNS, regardless of specialty, population, or setting.

Twenty-seven individuals representing twenty-two organizations (see Appendix 3 for a listing of participants) participated on the Task Force to identify and validate core CNS competencies. These individuals represented those most familiar with CNS practice and certification and included practicing CNSs, educators, managers, staff of organizations offering CNS certification, and members of the NACNS. From 2006 – 2008, the Task Force worked to identify and validate the core CNS competencies and behaviors identified in Appendix 5 of this document.

The Process

In preparation for the first meeting of the Task Force, the participating organizations were asked to submit their documents or publications that described the CNS competencies pertinent to their specialties. At the first meeting of the Task Force, each of the CNS competencies identified in these publications were written on large sticky notes and posted for viewing. It was observed that some organizations did not have competencies specific to the CNS role, while others had competencies for a broader or blended APRN role. It was also noted that the terms "competency" and "standard" were used interchangeably. In addition, a variety of organizing frameworks were used, including the nursing process, AACN Certification Corporation's Synergy Model, and NACNS's Spheres of Influence.

In order to organize the hundreds of competencies, the Task Force agreed that the nursing process (Assessment, Diagnosis, Outcome Identification, Planning, Implementation, and Evaluation) would be used as a preliminary framework for organizing the competencies. In addition, the following categories were also added: Systems; Ethics; Legislative/Policy; Research/Evidence-Based Practice; Nursing/Nursing Team/Department; and Other. Each competency was then placed under the most relevant heading of the framework. Using a multi-voting strategy, each participant voted on the competencies they felt were most important to entry-level CNS practice. The competency statements were subsequently honed down to a list most reflective of entry-level competencies for all CNSs in practice.

The Task Force received a brief tutorial on how to write a competency statement including:

- describe only <u>one</u> behavior in each statement
- statements must be measurable
- CNS competencies are advanced: basic RN competencies already underpin CNS practice and should not be listed in the CNS competencies
- each element should [consider] or [reflect] the complexity of CNS clients, populations, and practice
- should address care of patients across the lifespan
- must be culturally and ethnically diverse and age appropriate.

Small groups were then tasked to edit or rewrite the competency statements falling under assigned headings.

Organizing Framework

Over the course of the next year, the Task Force met via a series of conference calls and completed a thorough review of the competencies clustered under each heading. During this time it was acknowledged that three different models exist for CNS practice: (1) the three spheres of influence as defined by NACNS; (2) the seven advanced practice nursing competencies as defined by Hamric and Spross; and (3) the Nurse Characteristics identified in the AACN Synergy Model. The organizing framework for this document, which is depicted in the Model found in Figure 1, reflects a synthesis of these three models.

In the Model, the three spheres of influence defined by NACNS (Patient, Nurse/Nursing Practice, and Organization/System) provide the foundation for CNS practice. The nine Advanced Practice Competencies identified by Hamric and Spross (Direct Care; Consultation; System Leadership; Collaboration; Coaching; Research; Ethical Decision-Making; Moral Agency; Advocacy) provide the context for the specific, measurable behavioral statements listed below each overarching competency and are imbedded in this foundation. The eight Nurse Characteristics identified in the AACN Synergy Model (Clinical Judgment, Facilitation of Learning, Response to Diversity, Clinical Inquiry, Systems Thinking,

Collaboration, Advocacy, Caring Practices), are also imbedded within this foundation. Patients and Families are the focus of the model, linking the framework together.

Validation of Core CNS Competencies and Specific Behaviors

Once the Task Force achieved consensus on the organizing framework, competency statements and specific behaviors were validated through a national web-based survey delivered via Survey Monkey. Each of the Task Force's participating organizations disseminated an email invitation to their CNS constituents to participate in the survey, found on the ANA's *Nursing World* website.

In addition to demographic information that included name, current practice role, specialty area of practice, and organization represented if applicable, survey respondents were asked to respond to the following for each competency and specific behavior statement:

- Is the competency necessary and relevant to entry-level practice of a CNS regardless of specialty, setting, or population?
- Is it specifically and clearly worded?
- Is it appropriate for entry-level?
- Any competencies or behaviors missing?
- Are competencies and behaviors stated specifically enough for student or faculty preparing the student?
- Are there terms that are unclear – if so, list.
- Any comments about organizing framework – logical, easy to follow, user friendly?

Survey Findings

2,156 respondents entered the survey and approximately 50% completed all questions. Approximately 1,030 completed most questions and approximately 323 completed the open-ended questions at the end of the survey. Most importantly, 57% of the respondents were CNSs and 20.5% were educators.

For the majority of the competency statements, the range of agreement was 90-98%. For the majority of behavioral statements the range of agreement was similar - 90% and above.

Consensus Achieved

At a face-to-face meeting held May 29-30, 2008 at ANA headquarters, the Task Force focused only on the data and comments from CNSs specifically. Working in small groups that were assigned a specific competency and set of behaviors, the Task Force accepted any competency and behavior with a range of agreement 90% or above. For range of agreement less than 90% but more than 80%, the Task Force determined whether or not to keep the statements and provided edits, based on survey participant feedback. The Task Force maintained the behavior statement (A.13) related to prescribing even though the agreement rating was 77% because the lower level of agreement is likely to be related to current restrictions on prescribing in multiple states, rather than to disagreement about the relevance of this competency.

By the end of this meeting, the Task Force achieved consensus on the final listing of competencies and behaviors found in Appendix 5 of this document.

Endorsement

In August, 2010 a letter and call for endorsement of the validated competencies and behaviors was disseminated by NACNS to a wide variety of stakeholders, including the organizations represented by Task Force members, APRN Consensus Work Group and National Council of State Boards of Nursing APRN Advisory Committee members. The call for endorsement noted that definitions of terms would be added at a later date. Twenty two organizations as listed in Appendix 6 have endorsed the document to date.

If your organization has not endorsed the document, it is not too late! In order to indicate your organization's endorsement, please email, mail, or fax a letter of endorsement to:

Ethan Gray
Executive Director of Operations
NACNS
100 North 20th Street, Suite 400
Philadelphia, PA 19103
Phone: 215-320-3881
Fax: 215-564-2175
Email: egray@fernley.com

A running list of endorsing organizations can be found on the NACNS website.

Summary

In summary, the process to identify and validate CNS core competencies and behaviors was a very inclusive, collegial and consensus-driven process, attesting to the professionalism of those involved and their commitment to providing the public with competent APRNs practicing in CNS roles.

NACNS has graciously agreed to be the "keeper" of this work and to engage a Task Force of the collective to update the core competencies and behaviors every five years using the process identified in the *Addendum: National Consensus-Building Process to Develop Nationally Recognized Education Standards and Role/Specialty Competencies* found in the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education, July 7, 2008; Addendum.*

Bonnie Niebuhr and Mary Jean Schumann thank the Task Force for their hard work on this national endeavor designed to identify core CNS competencies relevant to the entry-level CNS, regardless of specialty, population, or setting. In addition, the Task Force thanks both ABNS and ANA for their support of this project.

Endorsing organizations as well as other key stakeholder organizations are encouraged to post this Executive Summary on their websites to ensure the broad dissemination of the CNS core competencies and behaviors.

Questions about this document may be directed to:

Ethan Gray
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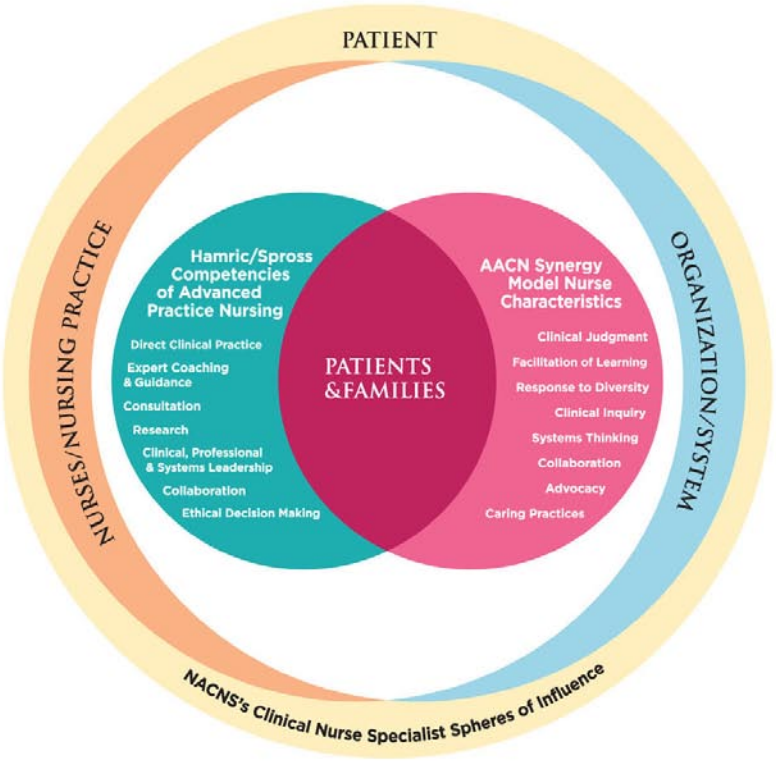

Figure 1. Model depicting organizational framework for CNS core competencies

APPENDIX 1 - APRN CONSENSUS PROCESS WORK GROUP

ORGANIZATIONS THAT WERE REPRESENTED AT THE WORK GROUP MEETINGS

Organization	Member Representative
American Academy of Nurse Practitioners Certification Program	Jan Towers
American Association of Colleges of Nursing	Joan Stanley
American Association of Critical Care Nurses Certification Corporation	Carol Hartigan
American Association of Nurse Anesthetists	Leo LeBel
American Board of Nursing Specialties	Bonnie Niebuhr
American College of Nurse-Midwives	Peter Johnson & Elaine Germano
American Nurses Association	Mary Jean Schumann
American Nurses Credentialing Center	Mary Smolenski
American Organization of Nurse Executives	M.T. Meadows
American Psychiatric Nurses Association	Edna Hamera & Sandra Talley
Association of Faculties of Pediatric Nurse Practitioners	Elizabeth Hawkins-Walsh
Commission on Collegiate Nursing Education	Jennifer Butlin
APRN Compact Administrators	Laura Poe
Council on Accreditation of Nurse Anesthesia Educational Programs	Betty Horton
National Association of Clinical Nurse Specialists	Kelly Goudreau
National Association of Nurse Practitioners in Women's Health, Council on Accreditation	Fran Way
National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties	Mimi Bennett
National Council of State Boards of Nursing	Kathy Apple
National League for Nursing Accrediting Commission	Grace Newsome & Sharon Tanner
National Organization of Nurse Practitioner Faculties	Kitty Werner & Ann O'Sullivan
Oncology Nursing Certification Corporation	Cyndi Miller-Murphy
Pediatric Nursing Certification Board	Janet Wyatt
Wound, Ostomy and Continence Nursing Certification Board	Carol Calianno
DHHS, HRSA, Division of Nursing *(observer)*	Irene Sandvold

(From the July, 2008 *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education.)*

APPENDIX 2 – ADDENDUM: EXAMPLE OF A NATIONAL CONSENSUS-BUILDING PROCESS TO DEVELOP NATIONALLY RECOGNIZED EDUCATION STANDARDS AND ROLE/SPECIALTY COMPETENCIES

The national consensus-based process described here was originally designed, with funding by the Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing, to develop and validate national consensus-based primary care nurse practitioner competencies in five specialty areas. The process was developed with consultation from a nationally recognized expert in higher education assessment. The process subsequently has been used and validated for the development of similar sets of competencies for other areas of nursing practice, including competencies for mass casualty education for all nurses and competencies for acute care nurse practitioners and psych/mental health nurse practitioners.

This process for developing nationally recognized educational standards, nationally recognized role competencies and nationally recognized specialty competencies is an iterative, step-wise process. The steps are:
Step 1: At the request of the organization(s) representing the role or specialty, a neutral group or groups convenes and facilitates a national panel of all stakeholder organizations as defined in step 2.
Step 2: To ensure broad representation, invitations to participate should be extended to one representative of each of the recognized nursing accrediting organizations, certifiers within the role and specialty, groups whose primary mission is graduate education and who have established educational criteria for the identified role and specialty, and groups with competencies and standards for education programs that prepare individuals in the role and specialty.
Step 3: Organizational representatives serving on the national consensus panel bring and share role delineation studies, competencies for practice and education, scopes and standards of practice, and standards for education programs.
Step 4: Agreement is reached among the panel members
Step 5: Panel members take the draft to their individual boards for feedback.
Step 6: That feedback is returned to the panel. This is an iterative process until agreement is reached.
Step 7: Validation is sought from a larger group of stakeholders including organizations and individuals. This is known as the Validation Panel.
Step 8: Feedback from the Validation Panel is returned to National Panel to prepare the final document.
Step 9: Final document is sent to boards represented on the National Panel and the Validation Panel for endorsement.

The final document demonstrates national consensus through consideration of broad input from key stakeholders. The document is then widely disseminated.

(Taken from the APRN Joint Dialogue Group. (2008). *The Consensus Model for Advanced Practice Registered Nurses (APRN): Licensure, Accreditation, Certification and Education*. Accessed May 27, 2009 at URL http://www.aacn.nche.edu/Education/pdf/APRNReport.pdf.).

APPENDIX 3 - NATIONAL CNS COMPETENCY TASK FORCE PARTICIPANTS

ORGANIZATION	MEMBER REPRESENTATIVE
American Assoc. of Critical-Care Nurses (AACN)	Ann Wojner Alexandrov, RN, PhD, CCRN, FAAN
National Association of Orthopedic Nurses (NAON)	Linda Altizer, MSN, RN, ONC, CLNC
National Association of Clinical Nurse Specialists (NACNS)	Kathleen Baldwin, PhD, RN, CNS, ANP
American Assoc. of Neuroscience Nurses (AANN)	Cathy Cartwright, RN, MSN, PCNS,
Association of periOperative Registered Nurses (AORN)	Robin Chard, PhD, RN, CNOR
Quad Council of Public Health Nursing Organizations	Sister Rosemary Donley, Ph.D., CRNP, ANP, R.N., FAAN
American Psychiatric Nurses Association (APNA)	Barbara L. Drew, PhD, PMHCNS-BC
Commission on Collegiate Nursing Education (CCNE)	Patti Eisenberg, MSN, APRN, BC
American Nephrology Nurses Association (ANNA)	Susan Fallone, RN, MS, CNN
National Association of Clinical Nurse Specialists (NACNS)	Christine Filipovich, RN, MSN
Association of Rehabilitation Nurses (ARN)	Cindy Gatens, RN, MN, CRRN-A
Oncology Nursing Society (ONS)	Ruth Gholz, RN, MS, AOCN
AACN Certification Corp.	Carol Hartigan, MA, RN
Association of Pediatric Oncology Nurses	Joy Hesselgrave, MSN, RN, CPON
American Association of Occupational Health Nurses	Eileen Lukes, PhD, RN, COHN-S, CCM, FAAOHN
Association of Women's Health, Obstetrics & Neonatal Nurses (AWHONN)	Audrey Lyndon, RNC, PhD, CNS
Commission on Collegiate Nursing Education (CCNE)	E. Jane Martin, PhD., RN, FAAN
Quad Council of Public Health Nursing Organizations	Jeanne A. Matthews, PhD, RN
Hospice and Palliative Nurses Association (HPNA)	Bridget Montana, MSN, APRN, MBA
Oncology Nursing Certification Corporation (ONCC)	Cynthia Miller Murphy, RN, MSN, CAE
National Association of Clinical Nurse Specialists (NACNS)	Theresa Murray, RN, MSN, CCRN, CCNS
Association of State & Territorial Directors of Nursing (ASTDN)	Shirley Orr, MHS, ARNP, CNAA
American Organization of Nurse Executives (AONE)	Pam Rudisill, MSN, RN, CCRN
Association of periOperative	Jacklyn Schuchardt, RN, MSN, CNOR

ORGANIZATION	MEMBER REPRESENTATIVE
Registered Nurses (AORN)	
Board of Certification for Emergency Nursing (BCEN) and Emergency Nurses Association (ENA)	Jacqueline Stewart, RN, MSN, CNS, CEN
American Association of Colleges of Nursing (AACN)	Judith Spross, PhD, RN, AOCN, FAAN
American Nurses Credentialing Center (ANCC)	Diane Thompkins, MS, RN
Board of Certification for Emergency Nursing (BCEN)	Darleen Williams, CNS, MSN, CEN, CCNS, CNS-BC, EMT-P
American Nurses Association (ANA)	Kathleen White, PhD RN, CNAA

APPENDIX 4 – DEFINITIONS AND REFERENCES

Advanced Nursing Practice - Advanced nursing practice is the application of an expanded range of practical, theoretical, and research-based competencies to phenomena experienced by patients within a specialized clinical area of the larger discipline profession of nursing.

Hamric, A.B. (2008). A definition of advanced nursing practice. In Hamric, AB, Spross, JA, & Hanson, CM., *Advanced Practice Nursing: An integrative approach* (pp. 85-108). St. Louis, MO: Saunders Elsevier, pp.85-108.

Advanced nursing therapeutics - Expert specialty skills in direct management of patients with complex acute and chronic illnesses across settings.

Hanson, C. M., & Hamric, A. B. (2003). Reflections on the continuing evolution of advanced practice nursing. *Nursing Outlook, 51*, 203-211.

Advocacy & Moral Agency - Working on another's behalf and representing the concerns of the patient/family and nursing staff; serving as a moral agent in identifying and helping to resolve ethical and clinical concerns within and outside the clinical setting.

S. Hardin, R. Kaplow. (2004). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care.* Aliso Viejo, CA: American Association of Critical Care Nurses.

Authentic engagement - A relationship between nurse and patient that is characterized by genuineness, honesty, trust, and being fully present.

Parse, R. R. (1988). Caring from a human science perspective. In M. M. Leininger (Ed.), *Caring: An Essential Human Need.* (pp. 129-132). Detroit, MI: Wayne State University Press.

Caring Practices - Nursing activities that create a compassionate, supportive, and therapeutic environment for patients and staff, with the aim of promoting comfort and healing and preventing unnecessary suffering. Includes, but is not limited to vigilance, engagement, and responsiveness of caregivers, including family and healthcare personnel.

S. Hardin, R. Kaplow. (2004). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care.* Aliso Viejo, CA: American Association of Critical Care Nurses.

Clinical Inquiry (Innovator/Evaluator) - The ongoing process of questioning and evaluating practice and providing informed practice. Creating practice changes through research utilization and experiential learning.

S. Hardin, R. Kaplow. (2004). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care.* Aliso Viejo, CA: American Association of Critical Care Nurses.

Clinical Judgment - Clinical reasoning which includes clinical decision-making, critical thinking, and global grasp of the situation, coupled with nursing skills acquired through a process of integrating formal and informal experiential knowledge and evidence-based guidelines.

S. Hardin, R. Kaplow. (2004). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care.* Aliso Viejo, CA: American Association of Critical Care Nurses.

Coaching – Skillful guidance and teaching to advance the care of patients, families, groups of patients, and the profession of nursing.

Hamric, AB, Spross, JA, & Hanson, CM. (2008). *Advanced Practice Nursing: An integrative approach*. St. Louis, MO: Elsevier.

Collaboration - Working with others in a way that promotes/encourages each person's contributions toward achieving optimal/realistic patient/family goals. Involves intra- and inter-disciplinary work with colleagues and community.

S. Hardin, R. Kaplow. (2004). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care.* Aliso Viejo, CA: American Association of Critical Care Nurses.

Collaboration – Working jointly with others to optimize clinical outcomes. The CNS collaborates at an advanced level by committing to authentic engagement and constructive patient, family, system, and population focused problem solving.

Hamric, AB, Spross, JA, & Hanson, CM. (2008). *Advanced Practice Nursing: An integrative approach*. St. Louis, MO: Elsevier.

Collaboration - Working with others in a way that promotes/encourages each person's contributions toward achieving optimal/realistic patient/family goals. Involves intra- and inter-disciplinary work with colleagues and community.

S. Hardin, R. Kaplow. (2004). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care.* Aliso Viejo, CA: American Association of Critical Care Nurses.

Consultation – Patient, staff, or system-focused interaction between professionals in which the consultant is recognized as having specialized expertise and assists consultee with problem solving.

Hamric, AB, Spross, JA, & Hanson, CM. (2008). *Advanced Practice Nursing: An integrative approach*. St. Louis, MO: Elsevier.

Competency - A "competency" is an expected level of performance that integrates knowledge, skills, abilities, and judgment.

ANA. (May 28, 2008). Professional Role Competence. American Association of Nurses.

Direct Clinical Practice – Direct interaction with patients, families, and groups of patients to promote health or well-being and improve quality of life. Characterized by a holistic perspective in the advanced nursing management of health, illness, and disease states.

Tracy, M.F. (2008). Direct clinical practice. In Hamric, AB, Spross, JA, & Hanson, CM. *Advanced practice Nursing: An integrative approach. 4th ed.* St. Louis: Elsevier.

Ethical Decision-Making, Moral Agency and Advocacy – Identifying, articulating, and taking action on ethical concerns at the patient, family, health care provider, system, community, and public policy levels.

Hamric, AB, Spross, JA, & Hanson, CM. (2008). *Advanced Practice Nursing: An integrative approach*. St. Louis, MO: Elsevier.

Evidence based practice - Use of current evidence in practice through the incorporation of clinical expertise and patient values and preferences with the systematic search for relevant scientific evidence to address clinical problems.

Melnyk, B.M. and Fineout-Overholt, E. (2005). Evidence-based practice in nursing and healthcare. Philadelphia: Lippincott Williams & Wilkins.

Facilitation of Learning - The ability to promote the education of patients/families, nursing staff, other members of the healthcare team, and community. Includes both formal and informal facilitation of learning.

S. Hardin, R. Kaplow. (2004). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care.* Aliso Viejo, CA: American Association of Critical Care Nurses.

Indirect Care – The provision of care through activities that influence the care of patients, but do not involve direct engagement with patients. Examples include developing evidence-based guidelines or protocols for care and staff development activities.

Tracy, M.F. (2008). Direct clinical practice. In Hamric, AB, Spross, JA, & Hanson, CM. *Advanced practice Nursing: An integrative approach. 4th ed.* St. Louis: Elsevier.

Non pharmacologic (and integrative) interventions - Nonpharmacologic and integrative interventions includes a range of conventional and less commonly used non-medication, complementary and alternative therapies for the alleviation of symptoms, stress, suffering and other human responses.

National Center for Complementary and Alternative Medicine. (2007, February). Fact Sheet – What is CAM? Retrieved April 25, 2010, from http://nccam.nih.gov/health/whatiscam/overview.htm.

Nurse Characteristics – As described in the AACN Synergy Model, nursing care reflects an integration of knowledge, skills, experience, and attitudes needed to meet the needs of patients and families. Thus, continuums of nurse characteristics are derived from patient needs.

S. Hardin, R. Kaplow. (2004). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care.* Aliso Viejo, CA: American Association of Critical Care Nurses.

Nurses/Nursing Practice – The CNS advances nursing practice and improve patient outcomes by updating and improving norms of care and by using standards of care that direct actions of nurses and nursing personnel.

NACNS (1998). *Statement on Clinical Nurse Specialist Practice and Education*. Harrisburg, PA., NACNS.

Nurse Sensitive Outcomes – Expected changes that reflect nursing care or care rendered in collaboration with other healthcare providers.

Oncology Nursing Society. (2004, July). *Nurse Sensitive patient Outcomes.* Retrieved April 25, 2010, from http://www.ons.org/Research/NursingSensitive/

Organization/System – The CNS articulates the value of nursing care at the organizational, decision-making level, and influences system changes that facilitate improvement of quality cost-effective patient outcomes.

NACNS (1998). *Statement on Clinical Nurse Specialist Practice and Education*. Harrisburg, PA., NACNS.

Outcomes - Refers to the expected changes in predetermined factors such as the patient's behavior, health status, or knowledge following the completion of nursing care.

S.J. Redfern, I.J. Norman,. (1990). Measuring the quality of nursing care: a consideration of different approaches. *Journal of Advanced Nursing, 15* (11), 1260-1271.

Patient Outcomes – An immensely complex construct. Spans a range of effects or presumed effects of nursing and, in a broader conceptualization, healthcare interventions. Outcomes are measured both directly and indirectly, over different periods of time and from vastly different sources of information. They vary according to perspective and have different degrees of reliability and validity.

S. Bond, L.H. Thomas. (1991). Issues in measuring outcomes of nursing. *Journal of Advanced Nursing, 16*(12), 1492-1502.

Response to Diversity - The sensitivity to recognize, appreciate, and incorporate differences into the provision of care. Differences may include but are not limited to cultural differences, spiritual beliefs, gender, race, ethnicity, lifestyle, socioeconomic status, age, and values.

S. Hardin, R. Kaplow. (2004). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care.* Aliso Viejo, CA: American Association of Critical Care Nurses.

Sphere of Influence – A model for CNS practice, articulated by the National Association of Clinical Nurse Specialists, based on three spheres of influence (Patient, Nurse, System) to reflect CNS practice as consistently targeted toward achieving quality, cost-effective outcomes through patient/client care, by influencing the practice of other nurses and nursing personnel, and by influencing the healthcare organization to support nursing practice.

NACNS (1998). *Statement on Clinical Nurse Specialist Practice and Education*. Harrisburg, PA., NACNS.

Specialty Competency – CNS specialty practice builds on core competencies and represents an interpretation and integration of the core competencies into the knowledge and skills of the specialty.

K.M. Baldwin, et al. (2007). Developing clinical nurse specialist practice competencies. *Clinical Nurse Specialist, 21* (6), 297-303.

Synergy - Results when the needs and characteristics of a patient, clinical unit or system are matched with a nurse's competencies.

S. Hardin, R. Kaplow. (2004). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care.* Aliso Viejo, CA: American Association of Critical Care Nurses.

Systems Leadership – The ability to manage change and empower others to influence clinical practice and political processes both within the across system.

Hamric, AB, Spross, JA, & Hanson, CM. (2008). *Advanced Practice Nursing: An integrative approach*. St. Louis, MO: Elsevier.

System Outcomes - The observed effects of interventions, health care practices, procedures or programs on departments, institutions, agencies or health systems on costs (savings, avoidance, reimbursement or revenue), resource use, risk avoidance or reduction, meeting quality and accreditation benchmarks and other institutional/agency/system impacts.

S. Hardin, R. Kaplow. (2004). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care.* Aliso Viejo, CA: American Association of Critical Care Nurses.

Systems Thinking - Body of knowledge and tools that allow the nurse to manage whatever environmental and systems resources exist for the patient/family and staff, within or across healthcare and non-healthcare systems.

S. Hardin, R. Kaplow. (2004). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care.* Aliso Viejo, CA: American Association of Critical Care Nurses.

APPENDIX 5 – CNS CORE COMPETENCIES AND BEHAVIORS WITH ASSOCIATED SPHERE OF INFLUENCE AND NURSE CHARACTERISTICS

A.	**<u>Direct Care Competency</u>: Direct interaction with patients, families, and groups of patients to promote health or well-being and improve quality of life. Characterized by a holistic perspective in the advanced nursing management of health, illness, and disease states.**		
	Behavioral Statement	**Sphere of Influence**	**Nurse Characteristics**
A.1	Conducts comprehensive, holistic wellness and illness assessments using known or innovative evidence-based techniques, tools, and direct and indirect methods.	Patient	Clinical Judgment
A.2	Obtains data about context and etiologies (including both non-disease and disease-related factors) necessary to formulate differential diagnoses and plans of care, and to identify and evaluate of outcomes.	Patient	
A.3	Employs evidence-based clinical practice guidelines to guide screening and diagnosis.	Patient & System	
A.4	Assesses the effects of interactions among the individual, family, community, and social systems on health and illness.	Patient	
A.5	Identifies potential risks to patient safety, autonomy and quality of care based on assessments across the patient, nurse and system spheres of influence.	Patient, Nurse & System	
A.6	Assesses the impact of environmental/system factors on care.	Patient & System	
A.7	Synthesizes assessment data, advanced knowledge, and experience, using critical thinking and clinical judgment to formulate differential diagnoses for clinical problems amenable to CNS intervention.	Patient & System	
A.8	Prioritizes differential diagnoses to reflect those conditions most relevant to signs, symptoms and patterns amenable to CNS interventions.	Patient	
A.9	Selects interventions that may include, but are not limited to: A.9.a. Application of advanced nursing therapies A.9.b. Initiation of interdisciplinary team meetings, consultations and other communications to benefit patient care A.9.c Management of patient medications, clinical procedures and other interventions A.9.d Psychosocial support including patient counseling and spiritual interventions	Patient	
A.10	Designs strategies, including advanced nursing therapies, to meet the multifaceted needs of complex patients and groups of patients.	Patient	
A.11	Develops evidence-based clinical interventions and systems to achieve defined patient and system outcomes.	Patient, Nurse & System	
A.12	Uses advanced communication skills within therapeutic relationships to improve patient outcomes.	Patient	Caring Practice

A.	**Direct Care Competency: Direct interaction with patients, families, and groups of patients to promote health or well-being and improve quality of life. Characterized by a holistic perspective in the advanced nursing management of health, illness, and disease states.**

	Behavioral Statement	**Sphere of Influence**	**Nurse Characteristics**
A.13	Prescribes nursing therapeutics, pharmacologic and non-pharmacologic interventions, diagnostic measures, equipment, procedures, and treatments to meet the needs of patients, families and groups, in accordance with professional preparation, institutional privileges, state and federal laws and practice acts.	Patient	Clinical Judgment
A.14	Provides direct care to selected patients based on the needs of the patient and the CNS's specialty knowledge and skills	Patient	
A.15	Assists staff in the development of innovative, cost effective programs or protocols of care	Patient, Nurse and System	
A 16	Evaluates nursing practice that considers Safety, Timeliness, Effectiveness, Efficiency, Efficacy and Patient-centered care.	Patient, Nurse & System	
A.17	Determines when evidence based guidelines, policies, procedures and plans of care need to be tailored to the individual	Patient	
A.18	Differentiates between outcomes that require care process modification at the individual patient level and those that require modification at the system level.	System	Systems Thinking
A.19	Leads development of evidence-based plans for meeting individual, family, community, and population needs.	Patient & System	Caring Practices
A. 20	Provides leadership for collaborative, evidence-based revision of diagnoses and plans of care, to improve patient outcomes	Patient, Nurse & System	Clinical Judgment

B.	**Consultation Competency: Patient, staff, or system-focused interaction between professionals in which the consultant is recognized as having specialized expertise and assists consul tee with problem solving.**

	Behavioral Statement	**Sphere of Influence**	**Nurse Characteristics**
B.1	Provides consultation to staff nurses, medical staff and interdisciplinary colleagues	Patient, Nurse & System	Clinical Judgment
B.2	Initiates consultation to obtain resources as necessary to facilitate progress toward achieving identified outcomes.	Patient	
B.3	Communicates consultation findings to appropriate parties consistent with professional and institutional standards.	Patient	Collaboration
B.4	Analyzes data from consultations to implement practice improvements.	Nurse & System	Facilitation of Learning

C.	**Systems Leadership Competency: The ability to manage change and empower others to influence clinical practice and political processes both within and across systems.**		
	Behavioral Statement	**Sphere of Influence**	**Nurse Characteristics**
C. 1	Facilitates the provision of clinically competent care by staff/team through education, role modeling, teambuilding, and quality monitoring.	Nurse & System	
C.2	Performs system level assessments to identify variables that influence nursing practice and outcomes, including but not limited to:	System	Systems Thinking
	C.2.a. Population variables (age distribution, health status, income distribution, culture)	Patient & System	Response to Diversity
	C.2.b. Environment (schools, community support services, housing availability, employment opportunities)	Patient & System	Systems Thinking
	C.2.c. System of health care delivery	Patient & System	
	C.2.d. Regulatory requirements	System	
	C.2.e. Internal and external political influences/stability	System	
	C.2.f. Health care financing	System	
	C.2.g. Recurring practices that enhance or compromise patient or system outcomes.	Patient, Nurse, & System	
C.3	Determines nursing practice and system interventions that will promote patient, family and community safety.	Nurse & System	
C.4	Uses effective strategies for changing clinician and team behavior to encourage adoption of evidence-based practices and innovations in care delivery.	Nurse & System	
C.5	Provides leadership in maintaining a supportive and healthy work environment.	System	
C.6	Provides leadership in promoting interdisciplinary collaboration to implement outcome-focused patient care programs meeting the clinical needs of patients, families, populations and communities.	Patient & System	Collaboration
C.7	Develops age-specific clinical standards, policies and procedures.	System	Collaboration & Response to Diversity
C.8	Uses leadership, team building, negotiation, and conflict resolution skills to build partnerships within and across systems, including communities.	System	Collaboration
C.9	Coordinates the care of patients with use of system and community resources to assure successful health/illness/wellness transitions, enhance delivery of care, and achieve optimal patient outcomes.	Patient & System	

C.	**Systems Leadership Competency: The ability to manage change and empower others to influence clinical practice and political processes both within and across systems.**		
	Behavioral Statement	**Sphere of Influence**	**Nurse Characteristics**
C.10	Considers fiscal and budgetary implications in decision making regarding practice and system modifications. C.10.a. Evaluates use of products and services for appropriateness and cost/benefit in meeting care needs C.10.b. Conducts cost/benefit analysis of new clinical technologies C.10.c. Evaluates impact of introduction or withdrawal of products, services, and technologies	System	Systems thinking
C.11	Leads system change to improve health outcomes through evidence based practice:	Patient, Nurse, System	Systems Thinking
	C.11.a. Specifies expected clinical and system level outcomes.	Patient, Nurse, System	
	C.11.b.Designs programs to improve clinical and system level processes and outcomes.	Patient, Nurse, System	
	C.11.c.Facilitates the adoption of practice change	Patient, Nurse, System	
C.12	Evaluates impact of CNS and other nursing practice on systems of care using nurse-sensitive outcomes	Nurse & System	
C.13	Disseminates outcomes of system-level change internally and externally	System	

D.	**Collaboration Competency: Working jointly with others to optimize clinical outcomes. The CNS collaborates at an advanced level by committing to authentic engagement and constructive patient, family, system, and population-focused problem-solving**		
	Behavioral Statement	**Sphere of Influence**	**Nurse Characteristics**
D.1	Assesses the quality and effectiveness of interdisciplinary, intra-agency, and inter-agency communication and collaboration.	Nurse, System	Clinical Inquiry & Collaboration
D.2	Establishes collaborative relationships within and across departments that promote patient safety, culturally competent care, and clinical excellence	System	Collaboration & Response to Diversity
D.3	Provides leadership for establishing, improving, and sustaining collaborative relationships to meet clinical needs.	Nurse, System	
D.4	Practices collegially with medical staff and other members of the healthcare team so that all providers' unique contributions to health outcomes will be enhanced.	Nurse, System	
D.5	Facilitates intra-agency and inter-agency communication.	Nurse, System	

E.	**Coaching Competency: Skillful guidance and teaching to advance the care of patients, families, groups of patients, and the profession of nursing.**		
	Behavioral Statement	**Sphere of Influence**	**Nurse Characteristics**
E.1	Coaches patients and families to help them navigate the healthcare system.	Patient Sphere	Advocacy & Moral Agency
E.2	Designs health information and patient education appropriate to the patient's developmental level, health literacy level, learning needs, readiness to learn, and cultural values and beliefs.	Patient Sphere	Facilitation of Learning & Response to Diversity
E.3	Provides education to individuals, families, groups and communities to promote knowledge, understanding and optimal functioning across the wellness-illness continuum.	Patient Sphere	
E.4	Participates in pre-professional, graduate and continuing education of nurses and other health care providers: E.4.a. Completes a needs assessment as appropriate to guide interventions with staff; E.4.b. Promotes professional development of staff nurses and continuing education activities; E.4.c. Implements staff development and continuing education activities;	Nurse	
	E.4.d Mentors nurses to translate research into practice.	Nurse	Facilitator of Learning & Clinical Inquiry
E.5	Contributes to the advancement of the profession as a whole by disseminating outcomes of CNS practice through presentations and publications.	Nurse	
E.6	Mentors staff nurses, graduate students and others to acquire new knowledge and skills and develop their careers.	Nurse	Facilitator of Learning
E.7	Mentors health professionals in applying the principles of evidence-based care.	Nurse & System	
E.8	Uses coaching and advanced communication skills to facilitate the development of effective clinical teams.	Nurse & System	Advocacy & Moral Agency
E.9	Provides leadership in conflict management and negotiation to address problems in the healthcare system.	Patient, Nurse & System	Collaboration

F. <u>Research Competency</u>: The work of thorough and systematic inquiry. Includes the search for, interpretation, and use of evidence in clinical practice and quality improvement, as well as active participation in the conduct of research.

I. Interpretation, Translation and Use of Evidence

Behavioral Statement		**Sphere of Influence**	**Nurse Characteristics**
F.I.1	Analyzes research findings and other evidence for their potential application to clinical practice	Patient, Nurse, & System	Clinical Inquiry
F.I.2	Integrates evidence into the health, illness, and wellness management of patients, families communities and groups	Patient	Clinical Inquiry
F.I.3	Applies principles of evidence-based practice and quality improvement to all patient care.	System & Patient	Clinical Inquiry
F.I.4	Assesses system barriers and facilitators to adoption of evidence-based practices.	System	
F.I.5	Designs programs for effective implementation of research findings and other evidence in clinical practice	Patient, Nurse, & System	
F.I.6	Cultivates a climate of clinical inquiry across spheres of influence:	Patient, Nurse, System	Clinical Inquiry, Systems Thinking
	F.1.6.a. Evaluates the need for improvement or redesign of care delivery processes to improve safety, efficiency, reliability, and quality.	Patient, Nurse, System	
	F.1.6.b. Disseminates expert knowledge;	Patient, Nurse, System	Facilitation of Learning

II. Evaluation of Clinical Practice

Behavioral Statement		**Sphere of Influence**	**Nurse Characteristics**
F.II.1	Fosters an interdisciplinary approach to quality improvement, evidence-based practice, research, and translation of research into practice	Nurse/Team	Collaboration
F.II.2	Participates in establishing quality improvement agenda for unit, department, program, system, or population	System	Clinical Inquiry
F.II.3	Provides leadership in planning data collection and quality monitoring.	System	
F.II.4	Uses quality monitoring data to assess the quality and effectiveness of clinical programs in meeting outcomes.	Patient, Nurse, & System	
F.II.5	Develops quality improvement initiatives based on assessments.	System	
F.II.6	Provides leadership in the design, implementation and evaluation of process improvement initiatives.	System	
F.II.7	Provides leadership in the system-wide implementation of quality improvements and innovations.	System	

F.	**<u>Research Competency</u>: The work of thorough and systematic inquiry. Includes systematic inquiry. Includes the search for, interpretation, and use of evidence in clinical practice and quality improvement, as well as active participation in the conduct of research.**		
III. Conduct of Research			
	Behavioral Statement	**Sphere of Influence**	**Nurse Characteristics**
F.III.1	Participates in conduct of or implementation of research which may include one or more of the following: F. III 1 a. Identification of questions for clinical inquiry F. III 1 b. Conduct of literature reviews F. III 1 c. Study design and implementation F. III 1 d. Data collection F. III 1 e. Data analysis F. III 1 f. Dissemination of findings	Patient, Nurse, & System	Clinical Inquiry

G.	**<u>Ethical Decision-Making, Moral Agency and Advocacy Competency</u>: Identifying, articulating, and taking action on ethical concerns at the patient, family, health care provider, system, community, and public policy levels.**		
	Behavioral Statement	**Sphere of Influence**	**Nurse Characteristics**
G.1	Engages in a formal self-evaluation process, seeking feedback regarding own practice, from patients, peers, professional colleagues and others	Nurse	Clinical Inquiry
G.2	Fosters professional accountability in self or others.	Nurse, System	Advocacy & Moral Agency
G.3	Facilitates resolution of ethical conflicts: G.3.a. Identifies ethical implications of complex care situations G.3.b Considers the impact of scientific advances, cost, clinical effectiveness, patient and family values and preferences, and other external influences. G.3.c. Applies ethical principles to resolving concerns across the three spheres of influence	Patient, Nurse, & System	Response to Diversity
G.4	Promotes a practice climate conducive to providing ethical care.	System & Nurse	Moral Agency
G.5	Facilitates interdisciplinary teams to address ethical concerns, risks or considerations, benefits and outcomes of patient care.	System & Nurse	Advocacy & Collaboration
G.6	Facilitates patient and family understanding of the risks, benefits, and outcomes of proposed healthcare regimen to promote informed decision making.	Patient	Facilitator of Learning
G.7	Advocates for equitable patient care by: G.7.a. Participating in organizational, local, state, national, or international level of policy-making activities for issues related to their expertise G.7.b. Evaluating the impact of legislative and regulatory policies as they apply to nursing practice and patient or population outcomes	Patient & System	Advocacy & Moral Agency

G.	**<u>Ethical Decision-Making, Moral Agency and Advocacy Competency</u>: Identifying, articulating, and taking action on ethical concerns at the patient, family, health care provider, system, community, and public policy levels.**		
G.8	Promotes the role and scope of practice of the CNS to legislators, regulators, other health care providers, and the public:	Nurse & System	Advocacy & Facilitator of Learning
	G.8.a. Communicates information that promotes nursing, the role of the CNS and outcomes of nursing and CNS practice through the use of the media, advanced technologies, and community networks.	Nurse & System	
	G.8.b. Advocates for the CNS/APRN role and for positive legislative response to issues affecting nursing practice.	Nurse, System	

APPENDIX 6 – ENDORSING ORGANIZATIONS AS OF NOVEMBER 1, 2010*

***(An ongoing, updated list of endorsers is available at www.nacns.org)**

1. AACN, American Association of Critical-Care Nurses & the AACN Certification Corporation
2. AACN, American Association of Colleges of Nursing
3. AANN, American Association of Neuroscience Nurses
4. ABNN, American Board of Neuroscience Nursing
5. AMSN, Academy of Medical-Surgical Nurses
6. ANNA, American Nephrology Nurses' Association
7. AORN, Association of periOperative Registered Nurses
8. APHON, Association of Pediatric Hematology/Oncology Nurses
9. APNA, American Psychiatric Nurses Association
10. ARN, Association of Rehabilitation Nurses
11. BCEN, Board of Certification for Emergency Nursing
12. CCNE, Commission on Collegiate Nursing Education
13. HPNA, Hospice and Palliative Nurses Association
14. INTNSA, International Nurses Society on Addictions
15. ISPN, International Society of Psychiatric-Mental Health Nurses
16. NBCHPN, National Board for Certification of Hospice and Palliative Nurses
17. NGNA, National Gerontological Nursing Association
18. NNSDO, National Nursing Staff Development Organization
19. ONCC, Oncology Nursing Certification Corporation
20. ONS, Oncology Nursing Society
21. SUNA, Society of Urologic Nurses and Associates
22. WOCNCB, The Wound Ostomy Continence Nursing Certification Board