Clinical Nurse/Midwife Specialist Role Resource Pack

2nd Edition

Identifying, Defining and Examining your CNS/CMS Role

Supporting the professional development of the CNS/CMS

JULY 2008

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Nursing and Midwifery Planning and Development Unit, Kilkenny

National Council for the Professional Development of Nursing and Midwifery

An Chomhairle Náisiúnta d'Fhorbairt Ghairmiúil an Altranais agus an Chnáimhseachais

Mission Statement of the National Council

The purpose of the Council is to promote and develop the professional roles of nurses and midwives in partnership with stakeholders in order to support the delivery of quality nursing and midwifery care to patients/clients in a changing healthcare environment.

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Foreword

On behalf of the National Council for the Professional Development of Nursing and Midwifery and the Nursing and Midwifery Planning and Development Unit (Kilkenny) we are extremely pleased to announce the publication of the second edition of the *Clinical Nurse/Midwife Specialist Role Resource Pack*. The original version was developed in 2003 by the Nursing and Midwifery Planning Development Unit (NMPDU) (Kilkenny) with funding from the National Council. It proved to be an important resource for clinical nurse and midwife specialists, many of whom were still adapting to their posts in a changing healthcare environment. The success of the first edition was reflected by the speed with which stocks were depleted and the continued requests for copies of the document.

In the intervening five years we have seen the growth in the number of posts from approximately 1,500 to 2,000, but the success story is not just about quantity. The National Council's evaluation of the effectiveness of the posts in 2005 demonstrated that they had been widely accepted and integrated within Irish health services and we hope that the forthcoming follow-up evaluation will provide rigorous and robust data about the outcomes of CNS-/CMS-provided care. By keeping in close communication with the services and developments in the higher education sector, we have ensured that the definition, core concepts, criteria for posts and post-holders, and administrative processes have been adjusted to meet changing needs. This work has led to the publication of second and third editions of the framework for CNS/CMS posts. Similarly, position papers by the National Council on specialist and advanced practice in emergency, intellectual disability and older person nursing have given clear guidance to specific types of service seeking to establish CNS posts, as have the service needs analysis guidelines.

The second edition of the *Clinical Nurse/Midwife Specialist Role Resource Pack* is the culmination of effective collaboration between national and regional bodies. This edition builds on the sound base provided by the first edition and incorporates the accumulated experience and expertise of both offices. A new first chapter outlines the developments in and relevant to the clinical career pathway that have taken place since the publication of the first edition in 2003. Elsewhere the references have been updated and text amended. A CD-ROM has been included which makes the templates and suggested activities more accessible. Finally, new case studies have been added with the aim of assisting the development of clinical specialist posts in intellectual disability, mental health, paediatrics and midwifery.

Our thanks are due to all at the National Council and the NMPDU in Kilkenny: Kathleen Mac Lellan, Head of Continuing Education and Professional Development, and Sarah Condell, Research Development Officer, National Council; and those who advised on the case studies. In particular we would like to thank Joan Gallagher, Project Officer, NMPDU (Kilkenny) and Christine Hughes, Professional Development Officer, National Council, for all their efforts in the production of this document.

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Glossary and Abbreviations

ALOS	average length of stay.
APEL	accreditation of prior experiential learning. The recognition of previous experience which the nurse/midwife is able to demonstrate has met specific learning outcomes relevant to a certified course of study (National Council 2006a).
APL	accreditation of previous learning. The recognition of previous learning (certified and/or uncertified) and the award of credits which count towards further studies or may be considered as an alternative or equivalent to certified entry requirements to particular courses (National Council 2006a).
CNE	centre of nurse education.
CNME	centre of nurse and midwife education.
CNS	clinical nurse specialist. See Chapter 1 of this document and publications by the National Council for more information.
CMS	clinical midwife specialist. See above.
Competence	"the ability to practise safely and effectively, fulfilling your professional responsibility within your scope of practice" (An Bord Altranais 2000).
CSF	critical success factor. See Chapter 2 (Section 2.6, Step 3) for a definition and more information.
CV	curriculum vitae. A CV is a document containing a summary or listing of job/work experience and education, usually for the purpose of obtaining an interview when seeking employment or a place on an education programme. It tends to be organised in a way that presents information about an individual in a compact fashion, with a clear chronology.
DoH	Department of Health (London, unless otherwise indicated). Log on to www.dh.gov.uk for more information.
DoHC	Department of Health and Children (Dublin). The DoHC's statutory role is to support the Minister in the formulation and evaluation of policies for the health services. It also has a role in the strategic planning of health services, which is carried out in conjunction with the Health Service Executive, voluntary service providers, Government Departments and other interested parties. Log on to www.dohc.ie for more information.

DySSY	Dynamic Standard Setting System. A quality improvement system based on Donabedian's structures, processes and outcomes approach and using a cycle of describing, measuring and taking action, resulting in the continuous improvement of care.
EBP	evidence-based practice.
HSE	Health Service Executive. A new body established in 2005 to provide health and social services for the people of Ireland (log on to www.hse.ie for more information).
HIPE	Hospital In-Patient Enquiry. HIPE is a computer-based discharge abstracting system designed to collect demographic, clinical and administrative data on discharges and deaths from acute general hospitals nationally. Log on to www.esri.ie/health_information/hipe/ for more information.
IPA	Institute of Public Administration. The IPA is the Irish national centre for development of best practice in public administration and public management.
KPA	key performance area. See Chapter 2 (Section 2.3) for more information.
MDT	multidisciplinary team. A multidisciplinary team is generally understood to denote a team comprising members of different professions working together for a common purpose or objective and is associated with the medical model of healthcare. In this case, the members of the MDT have individual strengths or abilities. The terms “multidisciplinary” and “interdisciplinary” are often used interchangeably but an interdisciplinary team is understood to be “an agent of change whose impact is the result of collective collaboration” between team members (Rokusek 1995).
National Council/NCNM	National Council for the Professional Development of Nursing and Midwifery. Log on to www.ncnm.ie for more information.
NHO	National Hospitals Office. Located within the Health Service Executive, the NHO is responsible for the strategic management of acute hospital services for the country.
NHS	National Health Service. UK-wide publicly funded health service provider. Log on to www.nhs.uk for more information.
NICE	National Institute for Health and Clinical Excellence - an independent organisation responsible for providing national guidance in the United Kingdom on promoting good health and preventing and treating ill health.
NMC	Nursing and Midwifery Council - the regulatory body for nurses and midwives in the United Kingdom. Log on to www.nmc-uk.org for more information.
NMPDU	nursing and midwifery planning and development unit. Eight such units were established in each of the original health boards between 2001 and 2002.

NQAI	National Qualifications Authority of Ireland. The NQAI is an agency of the Department of Education and Science and the Department of Enterprise, Trade and Employment, having responsibility for developing and maintaining the National Framework of Qualifications. Log on to www.nqai.ie for more information.
OHM	Office for Health Management. Now subsumed into the HSE's Employers' Agency. Log on to www.hseland.ie (the HSE's Learning and Development Performance and Development website) for more information and to download resources.
OPD	out-patient department.
PCCC	Primary, Community and Continuing Care. This refers to the Directorate of the Health Service Executive charged with responsibility for the provision of all health and personal social services (e.g., mental health, palliative care and social inclusion) available in the community setting through a network of thirty-two Local Health Offices.
PI	performance indicator. A quantifiable means of measuring the degree to which key objectives are achieved by individuals or by a service. Please refer to the Health Service Executive's current *National Service Plan* or other documents for examples of performance indicators. See Chapter 2 (Section 2.6, Step 5) for more information.
PDP	personal development plan. In the professional context a PDP is intended to help a practitioner plan and achieve development throughout his/her career.
Portfolio	a private collection of evidence which demonstrates the continuing acquisition of skills, knowledge, attitudes, understanding and achievement (Brown, 1995). When used by nurses and midwives a portfolio is generally understood to be an organised collection of documents chronicling an individual's career: these documents may then be drawn upon when applying for jobs or courses, or in order to demonstrate learning (National Council 2006a).
RCN	Royal College of Nursing. Log on to www.rcn.org.uk for more information and to download resources.
SEHB	South-Eastern Health Board. Now subsumed within the Health Service Executive.
SI	statutory instrument.
SMART	specific, measurable, achievable/agreed, relevant/realistic and time-bound. This refers to a way of evaluating whether the objectives being set for a project are appropriate. See Chapter 2 (Section 2.6, Step 4) and Chapter 4 (Section 4.4).

SWOT analysis	analysis of strengths, weaknesses, opportunities and threats. See Chapter 2 (Section 2.6, Step 2) for a definition and more information.
UK	United Kingdom.
US(A)	United States (of America).

Introduction to the Clinical Nurse/Midwife Specialist Role Resource Pack

The original *Clinical Nurse/Midwife Specialist Role Resource Pack* (2003) was developed by the Nursing and Midwifery Planning and Development Unit (NMPDU) in the former South-Eastern Health Board as part of a two-year project funded by the National Council for the Professional Development of Nursing and Midwifery (National Council). The aim of the resource pack was to support the professional development of the clinical nurse specialist/clinical midwife specialist (CNS/CMS), not just within the south-eastern region but right across the country. Using a modified version of a British specialist role evaluation pack (Hartley & Cowe 1997), the *Clinical Nurse/Midwife Specialist Role Resource Pack* was piloted with eighteen CNSs/CMSs. An education programme was developed concurrently to enhance its delivery and uptake. That first edition was based on the original framework for the establishment of CNS/CMS posts (National Council 2001a). Six years later these posts have become an integral part of the Irish health service, the National Council has twice revised the framework, other resources have been published and the health service is undergoing continuing reform and transformation. The second edition of the *Clinical Nurse/Midwife Specialist Role Resource Pack* now aims to help established post-holders to update their role and to assist novice post-holders to be successful in their new role.

This resource pack will assist you to:

- Identify and define your CNS/CMS role in line with the core concepts and associated competencies of the CNS/CMS as outlined by the National Council in 2007
- Reflect and examine your CNS/CMS role using the five core concepts and associated competencies as a framework for role clarification, evaluation and development
- Develop awareness of the strengths and areas for development within your CNS/CMS role and identify future priorities for development
- Formulate and implement a strategic plan for your CNS/CMS role and a personal development plan for your ongoing personal development
- Develop the skills to demonstrate and highlight the CNS/CMS unique and important contribution to patient/client care through audit and evaluation and through report writing, in particular, the annual report
- Identify mechanisms to establish clear inter- and intra-disciplinary communications
- Support a bid for additional resources, for example, extending CNS/CMS services, obtaining secretarial help, etc, through involvement in local business/operational plans.

The five core concepts of the CNS/CMS role (National Council 2007a) are common components to all specialist roles and so are used throughout the resource pack as the framework for role clarification, evaluation and development. This approach is based on the argument that to develop the CNS/CMS role in line with national and international expectations, specialists must compare their roles and demonstrate their effectiveness, in relation to the evidenced-based definition and five core concepts provided by the National Council (2007a).

USING THE *CLINICAL NURSE/MIDWIFE SPECIALIST ROLE RESOURCE PACK*

The *Clinical Nurse/Midwife Specialist Role Resource Pack* contains five chapters:

Chapter 1. Exploring the Definition and Five Core Concepts of the Clinical Nurse/Midwife Specialist Role

Chapter 2. Clinical Nurse/Midwife Specialist Role Clarification and Planning

Chapter 3. Competency Review and Personal Development Plans

Chapter 4. The Clinical Nurse/Midwife Specialist and Audit and Research

Chapter 5. The Clinical Nurse/Midwife Specialist and Report Writing.

The resource pack is designed so that each chapter can be read independently. Please ensure that you read the Introduction and Chapter 1 prior to reading any other section. The resource pack has a number of features designed to make it a more meaningful experience for you. These include the use of:

- Activity boxes and exercises for you to complete and reflect on the content in relation to your role and service
- Case studies of CNSs/CMSs illustrating answers to requested activities in the resource pack
- Appendices containing further templates for activities or examples from the literature
- A CD on which you will find the case studies and templates referred to above and other relevant information relating to the role of the CNS/CMS.

You will need a pen and paper to work your way through the activities contained in the resource pack. First, read through your chosen chapter and the recommended appendices to relate the chapter to your specialist role. Gather other relevant information from the literature or colleagues as required or as referred to in the chapter. There are no rights or wrongs about the time to spend working through this resource pack - you are the person best placed to look at your priorities and deadlines and make your own schedule. Nevertheless, feedback from the group of specialists who piloted this resource pack endorsed the view that the pack is best utilised when completed with the assistance of a colleague, peer and manager who knows you and your role. When scheduling time for role evaluation and development activities, take into account the time involved in setting up meetings and awaiting replies from others.

This pack is intended as a resource for you to “dip into” as required throughout the life of your CNS/CMS role and journey of CNS/CMS role development. Other activities that support role and professional development (e.g., reflective practice, clinical supervision, portfolio development and development of local support forums) will also support you in enhancing your role. While the National Council's own evaluation of the CNS/CMS role (National Council 2004b) has provided some evidence around the successful implementation of the role in Ireland, searching the literature for the available evidence on your specialist area will yield relevant information and ideas on the knowledge, skills and attitudes required to enhance and maximise the effectiveness of your role. Access to on-line journals and databases is recommended. All HSE employees can access these using an Athens password available from www.hselibrary.ie. Use of the HSE's on-line learning and development resource (www.hseland.ie) and its on-line e-learning programmes is also recommended.

The CNS's/CMS's line manager will be called upon to support the CNS/CMS in their professional development. This will include activities such as CNS/CMS role review and setting individual goals with the CNS/CMS. Familiarity with the CNS/CMS role definition, core concepts and associated competencies as well as individual job description will assist the line manager in supporting the CNS/CMS and agreeing joint expectations for the role.

The NMPDU and the National Council recommend the CNS/CMS undertakes role evaluation and development with the assistance of colleagues, peers and their line manager. Service users are also key informants on role evaluation. Changing ways of working is a complex process, which will only occur if front-line practitioners are actively engaged in leading the change and that such changes are planned and agreed with your colleagues, line manager, users of your service and other relevant stakeholders. The positive characteristics and personal qualities of the CNS/CMS identified in the preliminary evaluation of the CNS/CMS role (National Council 2004b, p38) outline the many skills and competencies required of the CNS/CMS to be innovative in achieving his/her priorities. Open discussion, clarification of expectations, encouraging networking and developing support mechanisms for the CNS/CMS will pay dividends. We hope the pack provides both CNS/CMSs and line managers with a useful tool for reflection, goal-setting and enhanced relationships between the CNS/CMS, the multidisciplinary team and their line managers with the overall aim of improving patient/client care.

REPRODUCING THE MATERIAL IN THE *CLINICAL NURSE/MIDWIFE SPECIALIST ROLE RESOURCE PACK*

If you are accessing the resource pack from the Internet or on disc, feel free to customise the material to meet your individual needs. You may reproduce or use this material without asking us, provided that you honour the following conditions:

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CHAPTER 1

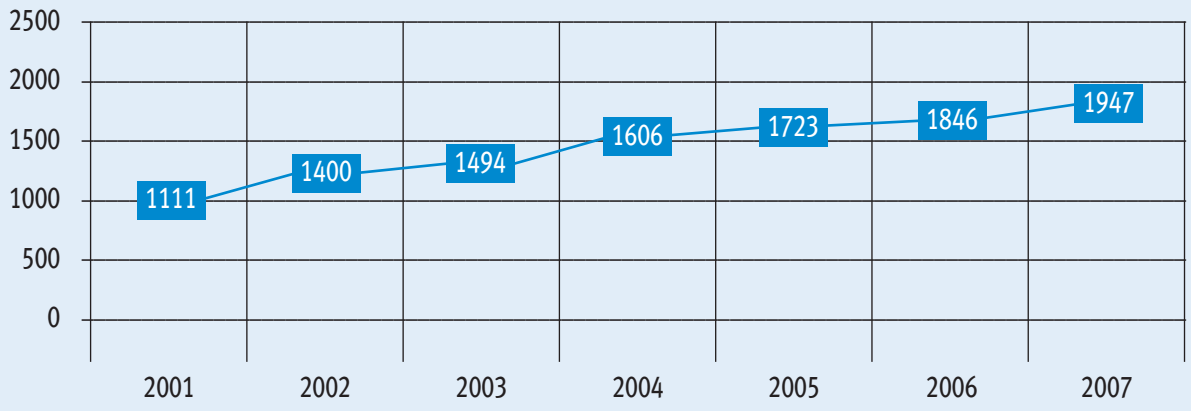
Exploring the Definition and Core Concepts of the Clinical Nurse/Midwife Specialist Role

1.1 BACKGROUND

In 1980 the Working Party on General Nursing first noted the need to develop "specialist nurses" in order to enhance the quality of nursing care; provide a specialist nursing service in certain nursing areas; provide specialist nursing advice to other nurses in those nursing areas; and enable more nurses to pursue a career in clinical nursing (Department of Health 1980, p67). The existence of clinical nurse specialist (CNS) and clinical midwife specialist (CMS) roles in Ireland was later acknowledged by the Commission on Nursing (Government of Ireland 1998), which also noted the need for "a coherent approach to the programme of specialisation and the development of a clinical career pathway in nursing and midwifery" (para 6.59, p111). In line with the recommendations of the Commission, the National Council for the Professional Development of Nursing and Midwifery (National Council) and the regional nursing and midwifery planning and development units (NMPDUs) were established in the early years of this decade. The definition of and criteria for CNS/CMS posts and post-holders were devised by the National Council, as were the application processes and procedures.

Applications for CNS/CMS posts were handled solely by the National Council under the immediate clinical career pathway, which operated until 30 April 2001, after which time the intermediate pathway commenced and applications were processed through the NMPDUs as these were gradually established in 2001 and 2002. The National Council and the NMPDUs now respectively maintain national and regional systems of recording posts and post-holders for the purposes of monitoring the development of specialist posts and to identify trends in this development. In the case of the National Council, this is in keeping with its statutory function of monitoring "the on-going development of nursing and midwifery specialities, taking into account changes in practice and service need" (SI No. 376, 1999). Since 2001 the number of CNS/CMS posts has increased from 1,111 to 1,947 at the end of 2007 (see Figure 1). National statistics relating to the number of posts in each Health Service Executive area and associated with each division of the Register are published on the National Council's website (www.ncnm.ie). Some examples of CNS/CMS posts in the different practising divisions of the Register are shown in Box 1.1.

FIGURE 1: GROWTH OF CLINICAL NURSE/MIDWIFE SPECIALIST POSTS 2001 - 2007



BOX 1.1: EXAMPLES OF AREAS OF SPECIALIST PRACTICE WITHIN THE PRACTISING DIVISIONS OF THE REGISTER (NATIONAL COUNCIL DATABASE 2008)

DIVISION OF REGISTER	EXAMPLE OF AREA OF SPECIALIST PRACTICE
Children's	Cardiac Services Cystic Fibrosis Dermatology Diabetes Infection Control
General	Breast Care Cardiac Disease, Cardiac Rehabilitation and Cardiology General Practice Oncology, Oncology Liaison and Cancer Care Respiratory Care
Intellectual Disability	Challenging Behaviour and Behaviour Management Community Intellectual Disability Nursing Early Intervention Health Promotion and Intervention Therapeutic and Development Programmes
Midwifery	Diabetes Drugs Liaison Foetal Assessment Lactation and Breastfeeding Ultrasound/Ultrasonography
Psychiatry	Addiction, Addiction Counselling and Detoxification Behaviour Therapy/Psychotherapy Child and Adolescent Mental Health Community Mental Health Psychiatry of Old Age

The framework for the establishment of CNS/CMS posts under the intermediate clinical career pathway has been revised twice since 2001 in light of the National Council's accumulated experience in dealing with CNS/CMS applications and management of the national database of such posts (National Council 2004a, 2007a; see Boxes 1.2 and 1.3). In this time there have been several developments in the healthcare sector that have been of relevance to the development of CNS/CMS posts. For example, the Health Service Reform Programme was launched in 2003 leading to the establishment of the Health Service Executive (HSE) in 2005. The former regional health boards and the Eastern Regional Health Authority, in which the eight NMPDUs had been established, were subsequently replaced by four administrative areas of the HSE. Structural and administrative changes are likely to continue.

BOX 1.2: PUBLICATIONS RELATING TO CLINICAL NURSE/MIDWIFE SPECIALIST POSTS AND ROLE DEVELOPMENT

CNS/CMS - Intermediate Pathway (April 2001)

Aid to Developing Job Descriptions/Profiles for Clinical Nurse/Midwife Specialist Posts (July 2001)

Guidelines on the Development of Courses Preparing Nurses and Midwives as Clinical Nurse/Midwife Specialists and Advanced Nurse/Midwife Practitioners (May 2002)

Clinical Nurse/Midwife Specialist Role Resource Pack (July 2003)*

An Evaluation of the Effectiveness of the Role of the Clinical Nurse/Midwife Specialist (January 2004)

Framework for the Establishment of Clinical Nurse/Midwife Specialist Posts - Intermediate Pathway (2nd edn) (November 2004)

Clinical Nurse Specialist and Advanced Nurse Practitioner Roles in Emergency Departments. Position Paper (April 2005)

Service Needs Analysis for Clinical Nurse/Midwife Specialist and Advanced Nurse/Midwife Practitioner Posts (September 2005)

Clinical Nurse Specialist and Advanced Nurse Practitioner Roles in Intellectual Disability Nursing. Position Paper No 2 (November 2006)

Framework for the Establishment of Clinical Nurse/Midwife Specialist Posts - Intermediate Pathway (3rd edn) (April 2007)

Clinical Nurse Specialist and Advanced Nurse Practitioner Roles in Older Persons Nursing. Position Paper No 3 (April 2007)

Enhanced Nursing Practice in Emergency Departments. Position Paper No 4 (April 2008)

Profiles of Advanced Nurse/Midwife Practitioners and Clinical Nurse/Midwife Specialists in Ireland (April 2008)

*Published by the NMPDU (Kilkenny), located in the former South-Eastern Health Board, and funded by the National Council.
All other documents in the above list were published by the National Council.
These publications may be downloaded from the National Council's website (www.ncnm.ie) or obtained on request.

In addition to the above changes, the Department of Health and Children (DoHC) has published health strategy documents that are subsidiary to the national health strategy *Quality and Fairness - A Health System for You* (DoHC 2001) and in some instances concern particular medical conditions or specific population groups. Other organisations and statutory bodies have also published reports that have implications for existing or potential CNS/CMS roles. These documents have enabled the National Council to provide clear and relevant guidance on factors to consider when determining the need for CNS/CMS posts and identifying the CNS's/CMS's caseload and job profile. For example, the position paper on the development of CNS posts in intellectual disability nursing (National Council 2006b) alludes not only to the particular health needs of people with intellectual disabilities but also to the philosophical debates influencing service provision for them.

The years from 2001 to the present have also witnessed the growth and development of specialised education programmes for nurses and midwives within the higher education sector. Nurses and midwives were facilitated to participate in these programmes by funding from the DoHC which was made available to cover fees for certain higher diploma programmes in specialist nursing and midwifery (DoHC Circulars 150/2000 and 47/2001). (Responsibility for funding is currently a human resource function within the HSE (Circular 11/05) and funding and sponsorship schemes are due to be reviewed in 2008.) In some instances, “seed funding” from the National Council has led directly to the creation and delivery of specialist nursing and midwifery modules within the third-level education sector. The development of these programmes has also been influenced by the work of the National Qualifications Authority of Ireland (NQAI). In particular, the National Framework of Qualifications (see www.nqai.ie and www.nfq.ie) has led to the requirement for nurses and midwives eligible to apply for CNS/CMS posts to “have undertaken formal recognised post-registration education relevant to his/her area of specialist practice at level 8 or above on the NQAI framework [of qualifications]” or to undertake the relevant level-8 education within three years (National Council 2007a, pp6-7).

Finally, the National Council has not only revised the framework for CNS/CMS posts (National Council 2004a, 2007a; see Box 1.3), it has provided guidance in relation to identifying the need for these posts and in relation to specific specialist areas such as emergency nursing, intellectual disability nursing and older person nursing. It has also conducted research into the effectiveness of the roles (National Council 2004b). The study showed that the roles had been well received by and integrated within the services (a second study of CNS/CMS roles will take place in 2008). The original *Clinical Nurse/Midwife Specialist Role Resource Pack* published in 2003 by the NMPDU in Kilkenny was also well received and has contributed to the understanding of CNS/CMS roles in Ireland.

BOX 1.3: SUMMARY OF CHANGES OCCURRING IN THE FRAMEWORK FOR THE ESTABLISHMENT OF CLINICAL NURSE/MIDWIFE SPECIALIST POSTS*

2004	*Aid to Developing Job Descriptions/Profiles for Clinical Nurse/Midwife Specialist Posts* (July 2001) incorporated within the Framework Employers required to prepare a competency-based job description for CNS/CMS posts and to update job descriptions as necessary Application form updated Financial approval form included
2007	"The person must have undertaken formal recognised post-registration education relevant to his/her area of practice at level 8 or above on the NQAI framework (ie, National Framework of Qualifications). If the person does not meet the educational criteria [...] then the person will still be eligible to apply for the post but must sign a contract with his or her employer stating that they will undertake the relevant post-registration level 8 education within three years." (National Council 2007, pp6-7)

* Please check the editions referred to for the exact wording.

1.2 DEFINITION AND CORE CONCEPTS OF THE CLINICAL NURSE/MIDWIFE SPECIALIST ROLE

The current edition of the *Framework for the Establishment of Clinical Nurse/Midwife Specialists Posts - Intermediate Pathway* (National Council 2007a) contains the definition, core concepts and associated competencies of the CNS/CMS role (see Boxes 1.4, 1.5 and 1.6 respectively).

The National Council's definition (2007a) identifies the main characteristics and functions of the CNS/CMS role. The criteria for the post state that the post "must have a major clinical focus" and allow for the post-holder "in consultation where necessary with the interdisciplinary team, to make clinical decisions based on agreed protocols" (National Council 2007a, p6). Nursing and midwifery practice is more diverse than ever before and the boundaries of inter- and intra-disciplinary practices are becoming increasingly blurred. Daly and Carnwell (2003) note that "confusion still abounds regarding the meaning, scope of practice, preparation for, and expectations of" new and advanced nursing roles. The CNS/CMS in Ireland is fortunate to have a clear and guiding definition of the specialist role for the Irish healthcare setting. The level of education and experience in addition to the post-holder's level of practice, autonomy and decision-making differentiates CNS/CMS posts from those of generalist nurses/midwives or advanced nurse/midwife practitioners.

BOX 1.4: DEFINITION OF THE ROLE OF THE CLINICAL NURSE/MIDWIFE SPECIALIST (NATIONAL COUNCIL 2007A, P5)

The area of specialty is a defined area of nursing or midwifery practice that requires application of specially focused knowledge and skills, which are both in demand and required to improve the quality of patient/client care. This specialist practice will encompass a major clinical focus, which comprises assessment, planning, delivery and evaluation of care given to patients/clients and their families in hospital, community and outpatient settings.

The area of specialty is a defined area of nursing or midwifery practice that requires application of specially focused knowledge and skills, which are both in demand and required to improve the quality of patient/client care. This specialist practice will encompass a major clinical focus, which comprises assessment, planning, delivery and evaluation of care given to patients/clients and their families in hospital, community and outpatient settings. The specialist nurse or midwife will work closely with medical and para-medical colleagues and may make alterations in prescribed clinical options along agreed protocol-driven guidelines.

The specialist nurse or midwife will participate in and disseminate nursing/midwifery research and audit and provide consultancy in education and clinical practice to nursing/midwifery colleagues and the wider interdisciplinary team.

A nurse or midwife specialist in clinical practice has undertaken formal recognised post-registration education relevant to his/her area of specialist practice at level 8 or above on the National Qualifications Authority of Ireland framework. Such formal education is underpinned by extensive experience and clinical expertise in the relevant specialist area. The level of practice of a CNS/CMS is higher than that expected of a staff nurse or midwife.

The five core concepts (see Box 1.5) are key components of the CNS/CMS role. They are clinical focus; patient/client advocacy; education and training; audit and research; and consultant.

BOX 1.5: THE FIVE CORE CONCEPTS OF THE CLINICAL NURSE/MIDWIFE SPECIALIST ROLE (NATIONAL COUNCIL 2007A, P7)

Clinical focus	The CNS/CMS must have a strong patient focus whereby the specialty defines itself as nursing or midwifery and subscribes to the overall purpose, functions and ethical standards of nursing. The clinical practice role may be divided into **direct** and **indirect care**. **Direct** care comprises the assessment, planning, delivery and evaluation of care to patients and their families. **Indirect** care relates to activities that influence others in their provision of direct care.
Patient/client advocate	The CNS/CMS role involves communication, negotiation and representation of the patient/client values and decisions in collaboration with other health care workers and community resource providers.
Education and training	The CNS/CMS remit for education and training consists of structured and impromptu educational opportunities to facilitate staff development and patient/client education. Each CNS/CMS in tandem with his/her line manager is responsible for his/her continuing professional development, including participation in formal and informal educational opportunities, thereby ensuring sustained clinical credibility among nursing/midwifery, medical and paramedical colleagues.
Audit and research	Audit of current nursing/midwifery practice and evaluation of improvements in the quality of patient/client care are essential requirements of the CNS/CMS role. The CNS/CMS must keep up to date with relevant current research to ensure evidence-based practice and research utilisation. The CNS/CMS must contribute to nursing/midwifery research, which is relevant to his/her particular area of practice. Any outcomes of audit and/or research should contribute to the next service plan.
Consultant	**Inter- and intra-disciplinary** consultations, across sites and services are recognised as key functions of the clinical nurse/midwife specialist. This consultative role also contributes to improved patient/client management.

The National Council provides further insight and definition of the components of the role through the five core concepts (Box 1.6) and the associated competencies. The five core concepts are necessarily broad statements in order to be “sufficiently capacious to facilitate individual specialist activities from within and across all disciplines of the nursing (midwifery) profession in Ireland” (National Council 2007a). The National Council (2007a) outlines the core concepts as the common practices of the CNS/CMS while recognising that individual specialities encompass unique knowledge and skills of their own. To enhance the development of specialist roles, from a planning and service need viewpoint, the National Council cite the International Council of Nurses (1992): “orderly development” of the roles will expand the depth, breadth and rigor of nursing (and midwifery) knowledge and expertise.

Lack of role definition adds to stress in the role (Bamford and Gibson 2000). Daly and Carnwell (2003) note that confusion still surround the meaning, scope of practice, preparation for, and expectations of new and advanced nursing roles. Having the National Council's CNS/CMS definition enables the CNS/CMS to define and clarify their own specialist roles in accordance with best practice. Bousfield (1997) states “the CNS is defined as a self-directed professional with considerable autonomy” (p254). The manner in which the role is performed, however, “will depend on many factors, among them professional competence, interpersonal skills and knowledge.” The National Council's preliminary evaluation of the CNS/CMS role in Ireland (National Council 2004b) also identified key characteristics of the post-holder necessary to be successful in the role.

The five core concepts are appropriate key performance areas for the CNS/CMS to evaluate and compare their roles as well as providing the CNS/CMS and their manager a framework to develop to assess and develop these factors in

their own specialist area. Before doing this, it is worthwhile looking more closely at the five core concepts and what they mean to the CNS/CMS.

Clinical Focus - Direct and Indirect Care

Your clinical focus is dependent on your area of specialist practice, caseload and work systems/environment/resources employed by you and your organisation in the delivery of your specialist service. Clinical focus is divided into two categories - direct and indirect care (Box 1.5) and must subscribe to the overall purpose, functions and ethical standards of nursing (International Council of Nurses 1992). The definition of the CNS/CMS (National Council 2007a) asserts that the "specialist nurse or midwife will work closely with medical and para-medical colleagues and may make alterations in prescribed clinical options along agreed protocol-driven guidelines" (p5). This requires the development of such protocols but also that you are clinically competent and credible in your area of specialist area. This ensures the provision of individualised, holistic, quality patient care based on best practice. Your indirect clinical focus incorporates activities that influence others (members of the multidisciplinary team, family or other carers) in the provision of care (National Council 2007a). This involves your ability to challenge and improve current practice, to act as a clinical leader, a change agent and to empower others through knowledge. To be effective in your clinical role, the level of autonomy and decision-making you have in your practice must be explicit. The National Council (2007a) also provides associated core competencies for this and each core concept (see Section 1.3 below). These competencies are relevant to all specialist roles. Individual role specific competencies relating to your area of practice should be in your job description and can be further developed with your line manager.

Patient/Client Advocacy

Advocating on behalf of patients/clients is not a function unique to the CNS/CMS or to other nurses/midwives: it is a sub-role of all health care professionals. However, it is given a particular emphasis for CNSs/CMSs in that it is a core concept of the role, especially in light of where you are placed in the health care service. The *Code of Professional Conduct for each Nurse and Midwife* (An Bord Altranais 2000) requires that any circumstance which could place patients/clients in jeopardy or which militate against safe standards of practice should be made known to appropriate persons or authorities. The advocacy role of the CNS/CMS goes beyond that of generalist nurses and midwives because of his/her unique contact with the patient/client and with other health professionals in the service. This unique contact puts the CNS/CMS in a position to empower patients/clients as consumers and autonomous decision makers (Mallik 2000). Advocacy requires skills in communicating, informing, advising, counselling, negotiating and representing patients/clients values and decisions on a range of health issues related to your specialist area. Advocacy can be undertaken on a group or individual basis but will always require collaboration with other professionals in various types of settings.

Education and Training

This concept relates to the structured and impromptu education and training to facilitate staff development and patient/client education (National Council 2007a). Again, the specifics of who the patient/client and other staff are should be apparent in your job profile and relate to your specialist area. The competent provision of training and education requires knowledge and skills in facilitation, needs analysis, communication, presentation and skills in establishing and evaluating an education programme for patients and/or staff.

Audit and Research

The role of the specialist involves auditing current practice and evaluating the quality of patient care (National Council 2007a). This requires that you are proactive in auditing your service in order to assess the effectiveness of your service and to improve the quality of patient/client care. As a CNS/CMS, you must be well informed and up to date with current research relevant to your practice role and setting. Contributing to nursing/midwifery research relevant to your specialist area is also a part of the CNS/CMS role. Audit and Research are discussed further in Chapter 4 of the resource pack.

Consultant

Consultancy involves the CNS/CMS acting as a specialist resource to improve patient/client management. The consultant-consultee relationship is often complex. As a CNS/CMS, you act as a consultant on issues within your remit, primarily specialist clinical nursing/midwifery practice. Those consulted may be members of the multidisciplinary team, nursing/nursing staff and other health professionals from within (internal) or outside (external) of your organisation.

1.3 THE CORE COMPETENCIES OF THE CLINICAL NURSE/MIDWIFE SPECIALIST

The National Council has stated that the competence of a CNS/CMS encompasses that of a nurse or midwife practising at primary level, and as such, the necessary competencies for entry to registration as deemed by An Bord Altranais are pre-requisites to specialist practice. Competencies for specialist practice may be catergorised into *core*

BOX 1.6. THE CORE COMPETENCIES OF THE CLINICAL NURSE/MIDWIFE SPECIALIST SPECIFIC TO EACH CORE CONCEPT

CORE CONCEPT	ASSOCIATED COMPETENCIES
Clinical focus	The CNS/CMS: • Articulates and demonstrates the concept of nursing and midwifery specialist practice within the framework of relevant legislation, the *Scope of Nursing and Midwifery Practice Framework* (An Bord Altranais 2000), *The Code of Professional Conduct* (An Bord Altranais 2000) and *Guidelines for Midwives* (An Bord Altranais 2001) • Possesses specially focused knowledge and skills in a defined area of nursing or midwifery practice at a higher level than that of a staff nurse/midwife • Performs a nursing/midwifery assessment, plans and initiates care and treatment modalities within agreed interdisciplinary protocols to achieve patient/client-centred outcomes and evaluates their effectiveness • Identifies health promotion priorities in the area of specialist practice • Implements health promotion strategies for patient/client groups in accordance with public health agenda
Patient/client advocacy	• Enables patients/clients, families and communities to participate in decisions about their health needs • Articulates and represents patient/client interests in collaboration with the interdisciplinary team • Implements changes in healthcare service in response to patient/client need and service demand
Education and training	• Provides mentorship, preceptorship, teaching, facilitation and professional supervisory skills for nurses and midwives and other healthcare workers • Educates patients/clients, families and communities in relation to their healthcare needs in the specialist area of practice • Identifies own continuing professional development needs and engages accordingly
Audit and research	• Identifies, critically analyses, disseminates and integrates nursing/midwifery and other evidence into the area of specialist practice • Initiates, participates in and evaluates audit • Uses the outcomes of audit to improve service provision • Contributes to service planning and budgetary processes through use of audit data and specialist knowledge
Consultancy	• Provides leadership in clinical practice and acts as a resource and role model for specialist practice • Generates and contributes to the development of clinical standards and guidelines • Uses specialist knowledge to support and enhance generalist nursing/midwifery practice

and *specific* competencies. Core competencies are those that emerge from the core concepts of the role of the CNS/CMS (see Box 1.6). The core competencies of the CNS/CMS are shared by all who practise at specialist level. Specific competencies are those identified as specific to the practice role and setting. Due to the diverse nature of roles and settings, the service provider is responsible for determining specific competencies for a particular role and outlining these in the job description. The *Clinical Nurse/Midwife Specialist Role Resource Pack* can be used for this purpose.

The above review of the definition, core concepts and associated core competencies of the CNS/CMS role are provided to assist you to relate and apply the role of the specialist as defined by the National Council to your own role. Further examples of the application of the role to the specialist area are provided throughout the resource pack, in the appendices and on the CD-ROM enclosed with this pack.

CHAPTER 2

Clinical Nurse/Midwife Specialist Role Clarification and Planning

"If professional nursing practice is to be valued, CNS posts must be well defined in relation to the nursing role. Lack of clarity in itself can lead to a diminution of the role as the CNS attempts to be 'all things to all people'."

(Hamric & Spross 1983; cited in Bousfield 1997, p254).

2.1 INTRODUCTION

This chapter provides you the reader with exercises and tools to enable you to:

- Clarify your specialist role in line with the National Council's definition and five core concepts
- Identify the scope and boundaries to your role
- Pin-point what is required of you to deliver the results expected in your role
- Construct a "strategic plan" for your role.

Chapter 2 is divided into five sections, each of which can be studied independently, allowing you to utilise the resource pack at your own pace. Throughout the chapter there are activities for you to carry out; you are also directed to the appendices to gain further information relevant to clarifying and planning your role. When working through Chapter 2, it is important that you take an all-inclusive "helicopter view" of your role. Incorporate the views, expertise and expectations of colleagues, peers, relevant professional bodies, managers and other members of the multidisciplinary team(s) associated with your specialist area. Therefore, when scheduling time for role evaluation and development activities, take into account the time involved in gathering information, setting up meetings, waiting for replies from others and your other priorities.

Central to the processes outlined in this chapter are the National Council's definition and five core concepts of the clinical nurse/midwife specialist (CNS/CMS) role. These outline the expectations of the specialist role. Chapter 2 assumes that you are familiar with the theory and practice of your specialist area as well as the definition and the five core concepts of the CNS/CMS role. If you have not already done so, read Chapter 1 of the resource pack - *Exploring the Definition and Five Core Concepts of the CNS/CMS Role* and parts 2, 3, 5 and 6 of the *Framework for the Establishment of Clinical Nurse/Midwife Specialist Posts - Intermediate Pathway* (National Council 2007a).

The sections in Chapter 2 are:

Developing a Role Purpose Statement - *Why does the role exist?*
A role purpose statement is recommended to ensure that there is clarity regarding the reasons for your involvement in activities, prior to their engagement. This statement answers the questions why does this role exist at all and what is it setting out to achieve?

Reviewing your Key Performance Areas - *What areas within your role must you excel in to be successful and how much time do you need to spend in each of these areas?*
Here you are asked to identify which aspects of your role are critical to achieving your overall role purpose. The National Council (2007a) identify the five core concepts as key performance areas common to all specialist roles. Your key performance areas should be centred on these core concepts.

Carrying out an Activity/Contact Analysis - *What precise activities are you carrying out and how do they link into your key performance areas?*
This section examines the time your currently spend on specific activities in each of the core concepts and asks you to compare that to the amount of time you think you should ideally be spending in that area. Comparing the real with the ideal encourages you to evaluate how efficiently you are utilising your time and to highlight areas you would like to change.

Identification of Key Stakeholders - *Who are the people, groups, organisations or strategies/policies that are important to and influence your role?*
To take a "helicopter view" of your role you must be able to identify those people whose contributions are critical to the success or otherwise of your role. This section will assist you to identify these stakeholders and judge the strength of their influences and whether they are enablers or barriers to the achievement of your role.

Strategic Planning - *What are the necessary steps to take to achieve your goals for your role?*

Step 1: Establishing Strategic Direction - What is your vision/mission statement for the future of your role/specialist area?

Step 2: Gathering Information - Where are we now?
This sub-section discusses stocktaking in your role and carrying out a SWOT analysis.

Step 3: Analysing the Present Situation - How will we achieve our goals?
Building on your key performance areas, what are the critical success factors to achieve your goals? This sub-section involves setting SMART objectives and identifying key outcome measures for your success factors.

Step 4: Taking Strategic Action - develop an operational plan to implement your strategy.

The final section on strategic planning asks you to concentrate on a deliberate planning process that assists you to achieve your role purpose/function and to address components of your role you wish to develop.

As a specialist in your area of clinical practice, you are asked to visualise the future of your specialist role and to incorporate this vision for the future in the activities of your role. The National Council's definition, five core concepts and associated core competencies of the CNS/CMS role are used as a framework to review your role and to develop a realistic, relevant plan. This requires that your plan has a sensible timeframe attached, achievable milestones or targets and clearly states how you intend to achieve these milestones. Your strategic plan should also demonstrate the effectiveness of your role and your role's important contribution to patient/client care and to nursing/midwifery.

Making Role Clarification and Planning Work

Chapter 2 asks you to reflect on the National Council's definition of the CNS/CMS role and compare your role against the National Council's definition and five core concepts. It is important that you consider your service, role activity and service development needs with your patients/clients in mind. If you are new to your role or to role evaluation and clarification, look to others for assistance, e.g., a colleague and your line manager. Bear in mind the demands of your working environment when planning meetings and try to keep to agreed frequency and duration for meetings. Take each section of Chapter 2 one at a time. Elicit the views of your stakeholders to ensure your answers are complete and reflect your patient/client and organisation's needs. Whatever your objectives may be, developing a realistic and strategic plan for your role can only help to achieve those objectives. It is important that your plan incorporates your values and attitudes, is well informed (by service plans, national or regional policy, nursing/midwifery literature, the "consumers" of your service, etc) and anticipates the future needs of your patients/clients and your professional role. Throughout the process you have to differentiate between what is a realistic expectation and objective for your role and what is a "wouldn't it be nice if..." objective but not one to be pursued at present. This requires that you liaise with colleagues and your manager to discuss, agree and develop your professional role and to take stock of where you are now with your career and service development. Also remember Chapter 2 is about developing a service or specialist role plan rather than a personal development plan around your learning needs. Reflecting on your personal development needs and writing a plan to meet these needs

comes later in Chapter 3.

Review your service/role strategic plans on a regular basis to ensure that milestones are being met. Celebrate and publicise your successes but also report where you are not meeting your targets, stating why and what you are doing about it. This may mean amending your original plan, which may have been overambitious to start with. Revisions in your plans should be clearly communicated to relevant stakeholders. Your line manager often requires progress and interim reports and your strategic plan should assist you in these reports. The five core concepts and their associated competencies are central to this chapter and can be used as a framework to guide all aspects of your role development. However, you still have control and can direct your role and strategic plan to meet your individual needs, your organisation's needs and the needs of your patient/client group under each of the core concept heading.

2.2 ROLE PURPOSE STATEMENT

The term *role* in this pack refers to the function/expected function of your job/position within your service and organisation. It is important that you can articulate your role purpose clearly to others. A role or job purpose statement aims to answer the following questions: why does this role exist? What difference would it make if the role was not there? The answers to these questions in relation to your specialist role should help you to identify what your role purpose is. Your job description may have your role purpose clearly articulated. It is vital that you have a clear understanding of the key purpose of your role, as it should be the foundation stone of any activity you carry out. Later, you can use or develop your statement into actual standard statements and targets as part of a performance measurement tool. To clarify and agree your role purpose statement may take longer than you think because of the potential diversity of the CNS/CMS roles. There is a need to ensure your role statement reflects the National Council's definition of the CNS/CMS, your unique nursing/midwifery care as well as meets the expectations of others in your organisation (e.g. patients/clients, managers and other relevant clinicians).

ACTIVITY 1 - Role Purpose Statement

You may find it useful at this point to take time out and revise your knowledge of the definition and the five core concepts of the CNS/CMS role (National Council 2007a). Revisiting your job description (if current) may also be worthwhile.

With the above and your specialist area in mind, write out your role purpose statement, using the three prompts provided below in Activity 1. Examples of statements are also provided. Review and validate your statement with a CNS/CMS colleague, your manager and/or relevant clinician. A Word version of this activity is available on the CD-ROM accompanying this pack.

ACTIVITY 1: *ROLE PURPOSE STATEMENT*

The aim of my role is ...

In order to ...

So that ...

Example 1: Role Purpose Statement from CNS/CMS Pilot Group (2003)

> *The aim of my CNS/CMS role is to ensure that the specialised knowledge and skills in my area of speciality are utilised to facilitate the provision of a quality client-focused service that enhances the health status of the population.*

The pilot group's role purpose statement above emphasises the difference between ensuring the provision of a high-quality service to patients/clients and providing a high-quality service. The influence that the CNS/CMS can

have on the quality of nursing care is not limited to those patients/clients he/she personally attends (Bousfield 1997). Effective implementation of indirect care roles, such as teacher, researcher, change agent and role model, are "essential if CNSs are to influence the quality of care in general rather than only for those for whom they provide direct care" (Spross & Baggerley 1989, p30). This aspect of why your role exists is worth reflecting on when deciding the purpose of your role.

CASE STUDY: *MARY - CNS (ASTHMA)*

Mary's Role Purpose Statement

Mary is based in the respiratory unit of St Blanaid's Hospital, a Band 1 acute hospital.

"The aim of my job as CNS (Asthma) is to utilise my specialist knowledge and the five core concepts of the specialist role to lead and maintain a holistic, person-centred, high-quality asthma nursing service to patients attending St Blanaid's hospital so that these patients will achieve their maximum health potential and receive timely, holistic and effective nursing care."

(Note: Other case studies are available on the CD-ROM accompanying this pack.)

In this example, Mary, the CNS (Asthma) recognises she cannot see all the patients/clients with asthma attending the hospital; but she may say she is doing her best to ensure that a quality service is being provided to all asthma patients in contact with her service through her clinical and professional leadership and by employing all five core concepts in her role. Leading and maintaining a quality system will include:

- educating staff on the front-line in best practice for the general management of asthma care (the core concepts involved are education and training, indirect clinical focus and research element of audit and research)
- developing referral systems and streamlining referrals to ensure she is reviewing the patients who really need access to her (core concept - consultant)
- evaluating the quality of patient care (clinical outcomes) and the level of patient satisfaction (core concept - audit and research).

2.3 THE FIVE CORE CONCEPTS AND ASSOCIATED CORE COMPETENCIES AS KEY PERFORMANCE AREAS

Once you have defined the purpose of your role, you can review the key performance areas required to achieve your role purpose and maximise the effectiveness of your role.

The five core concepts of the CNS/CMS role and the associated core competencies (National Council 2007a) are key performance areas for the specialist role. They are discussed in Chapter 1 of the resource pack. By attending to that each core concept when executing your role, you will maximise the potential effectiveness of your role and ensure that your practice is meeting the expectations of your guiding professional body, your employer and your role purpose statement.

The amount of time you allocate to each concept has not been defined by the National Council or your employer. The activities in this section aim to help you assess the actual time you currently spend on carrying out the functions of your role. You are then asked to reflect and identify the time you would ideally need to spend on these components of your role to be effective in your role and to achieve your role purpose statement. It is recognised that the amount of time you spend on a specific core concept will fluctuate. Priorities regarding caseload, deadlines, changes in clinical practice and the structure of your services are some things that will influence the amount of time you spend on any given area. However, the CNS/CMS is advised to review his/her work and activities regularly (once a month, once every three months, once a year, etc) in order to ensure that no core concept is overlooked. Activity 2 is intended to help you manage your time.

ACTIVITY 2 - Key Performance Areas

In the box below there are three columns to fill in. Column 1 asks you to prioritise the current importance of each core concept by ranking or rating them on a scale of 1 to 5. Scores of 1 or 5 indicates this is of the highest or lowest importance to your role. Column 2 asks you to estimate what percentage of your time you currently spend each month on activities associated with each concept. This should total 100% after you have entered a percentage for all five concepts. Column 3 asks you what percentage of your time you believe, ideally, you should spend on each concept (key performance area) in order to meet the goals you have set yourself within your role purpose statement. A Word version of this activity is available on the CD-ROM accompanying this pack.

ACTIVITY 2: *REVIEWING THE CORE CONCEPTS AS KEY PERFORMANCE AREAS*			
KEY PERFORMANCE AREA	**Column 1**	**Column 2**	**Column 3**
	Importance to role (on a scale of 1-5; 1 being of *very high importance* and 5 *of low importance)*	Current % of time/month spent on a core concept	Ideal % of time needed to achieve role purpose
Clinical Focus *Direct and indirect patient care*			
Patient/Client Advocacy *For individuals or groups*			
Education and Training *Patients/clients, staff and self*			
Audit and Research *Audit of current practice and quality of patient/client care; research utilisation and contributing to research*			
Consultancy *Inter- and intra-disciplinary; within and outside your service/organisation*			
Totals		100%	100%

If you find it difficult to quantify how much time you spend on activities associated with each core concept, you may find it useful to complete a time log sheet or diary. This can assist you to identify the amount of time you currently spend on role activities and by grouping the activities logged under each core concept heading, you can then estimate how much time you spend in each core concept/key performance area. The time log sheet or diary should be maintained ideally for a month but for no less than a fortnight. How to complete a time log diary is discussed in more detail in Chapter 5 of this resource pack. Appendix 1 contains examples of a time log sheet and diary that you can adapt to your role and complete on a daily basis. You may wish to modify the log sheet to reflect your specific role activities and specialist area. The reason the key performance area activity was placed first in the pack is because it is a focusing exercise to identify the key areas you need to pay attention to in your role. The details of your role activities and how they link into your key performance areas follow naturally and will provide you with data for other sections of this chapter and beyond. Some users of this pack may prefer to complete the more detailed CNS/CMS activity and contact analysis first (see Section 2.4 below) before reflecting on the broader key performance areas. The completed activity for Mary (CNS (Asthma), St Blanaid's Hospital) is displayed and explained below.

CASE STUDY: MARY - CNS (ASTHMA) *MARY'S KEY PERFORMANCE AREAS*

KEY PERFORMANCE AREA	Column 1 Importance to role (on a scale of 1-5; 1 being of *very high importance* and 5 *of low importance)*	Column 2 Current % of time/month spent on a core concept	Column 3 Ideal % of time needed to achieve role purpose
Clinical Focus	1	70%	60%
Patient/Client Advocacy	5	6%	6%
Education and Training	3	2%	12%
Audit and Research	2	5%	14%
Consultancy	4	13%	8%
Totals		100%	100%

Mary has been a CNS in asthma care for three years now. She has a large clinical caseload of children adolescents and adults with varying degrees of asthma. Having reviewed the needs of her patients/clients and St Blanaid's, Mary agreed that the clinical focus was the highest priority key performance area of her role but the large amount of time spent on direct clinical care was preventing her from spending time on the other core concepts/key performance areas of her role. Mary recognised that most of her time was spent on providing direct patient/client care which meant excellent care was being provided to those who saw her. She did not know, however, about the care of those who were not referred to her specialist service and she was aware that patients often had to wait for an OPD appointment after their discharge before she could see them. She recognised that even though there was a waiting list of patients/clients to see her and some of her review patients/clients no longer needed follow-up care in her clinics there was no protocol for prioritising referrals or discharging them from her care. This meant her clinical caseload has consistently increased. Thus, to attend to other aspects of her role and to make improvements in the long term she will need to change the amount of time spent solely on direct clinical care. She saw education of other key staff and clinical audit as the two areas she could focus on and which would provide benefits to the patients/clients, service and her own time management and ways of working.

Comparing her importance ratings and the time spent on the "education and training" and "audit and research" components of her role, Mary could see these roles were not being addressed as comprehensively they might have been. Time spent on audit and education had slipped in particular, though from her experience in the role Mary knew that for optimal effectiveness and/or to make changes in her service, performing in these core concepts would be crucial. By implementing education strategies (education sessions, updating staff and patient/client information leaflets, etc) she will develop her indirect clinical focus and enhance the quality of care to those patients/clients receiving care from other members of the team or in other departments of the hospital. This would aid her to reduce her own direct clinical care time as well as expanding the clinical service. So when other staff, through education, feel more competent and confident dealing with asthmatic patients/clients, she will receive fewer calls for regular general asthma care and can spend more time on those who need specialist interventions.

Currently, audit in her role relates to Mary being involved, as a member of the multidisciplinary team, in the activity analysis of the respiratory service/department. For some time now Mary has wanted to audit some of the new services she is directly involved in (an acute asthma home care package for children and their parents which has resulted in most asthma care being treated at home or in the emergency room with rapid discharge; an education programme for non-healthcare staff on asthma care developed in her second year in the role and the current adult asthma clinic to see if same could be better managed). Also Mary's line manager and the CNM2 she works closely with have indicated they would like to see an audit of "basic" asthma care - inhaler technique, knowledge of preventive/relief inhalers, etc, from patients'/clients' and staff's viewpoint. To make this a reality, Mary knows she has to find the time to start auditing. Currently this time will have to come from her direct clinical care and current amount of time spent on consultancy work but with improvements to care through better time management, education of others and audit, this will occur without harming her patients. In the future once audit is established as part of her regular workload, she could see that it will be more balanced with other concepts and hopefully be incorporated within her annual and daily activities.

Following review of her key performance areas, Mary recognised the fluidness of the concepts, how they overlap and all link into indirect clinical care of her patients/clients. Mary could see the benefits of applying the other core concepts to her work and realised that her priorities will change as the service change and monitoring time spent on key performance areas by repeating this exercise annually would help her be effective in her role and help prevent the amount of time spent on clinical focus building without a deterioration in service if the other core concepts were attended to in her role. (Case studies relating to key performance areas are available on the CD-ROM accompanying this pack.)

2.4 CLINICAL NURSE/MIDWIFE SPECIALIST ACTIVITY AND CONTACT ANALYSIS

Having completed your role purpose statement and broadly identified the time spent in each core concept/key performance area, it is useful to reflect on the specific activities pertinent to your role, under each core concept heading. The CNS/CMS activity analysis sheet (Activity 3) assists you to develop a clear picture of your regular activities and the time you spend on each activity. This is your opportunity to reflect on your actual work pattern. When completing the CNS/CMS activity analysis sheet, include the preparation time for the activity when calculating the amount of time spent on specific activities. Also estimate the amount of time spent on activities over an average fortnight or month. Refer to your time log sheets or diary (Appendix 1) to review your precise activities and to ensure you include them all. You may wish to add other activities than those mentioned on the activity analysis sheet below or be more specific about your activities, e.g., under direct contact with patients/clients, use subheadings of clinic contacts, ward or unit visits and home visits.

The following three-step approach is recommended when completing the activity/contact analysis (Hartley & Cowe 1997). You will need two copies of the activity sheet to complete the activity analysis. A copy of the CNS/CMS activity/contact analysis sheet and a blank activity sheet is available in Appendix 2 for you to modify, copy and distribute.

STEP 1: Complete one table to reflect your ***current*** working practices over an average fortnight/month. You may identify a discrepancy between the time spent and importance columns, for example, aspects ranked of low importance may be taking up large amount of time.

STEP 2: Complete a second table, reflecting your ***ideal*** job structure.

STEP 3: ***Compare*** the columns in the two tables. This may highlight, for example, that currently administration and clerical scores highly, when in your ideal role this is not a priority.

When comparing your scores, if your regular activities are not helping you to achieve your role purpose statement and fulfil a core concept of your role, you need to ask yourself why are you spending time on these activities?

The CNS role is susceptible to role conflict and role ambiguity, both of which can be frustrating and stressful (Bamford & Gibson 2000; Glen & Waddington 1998; Hamric & Taylor 1989). Glen and Waddington (1998) explain that role conflict occurs when the expectations of two or more key stakeholders are incompatible; role ambiguity occurs when there is lack of clarity regarding what those expectations actually are. Thus it is important that you share a common vision and clear expectations for your role with your line manager and other relevant key stakeholders. Hartley and Cowe (1997), who developed the original activity/contact analysis sheet, recommend asking a manager to also complete Activity 3. This allows you to reflect on your manager's expectations of your working patterns. Comparing this to your actual work can act as a trigger for further discussion. You could also ask a colleague and/or other relevant clinicians who your work closely with to complete an activity analysis sheet.

A Word version of this activity is available on the CD-ROM accompanying this pack. Below are suggested activities under each concept you may like to edit or adapt to the needs of your specialist area.

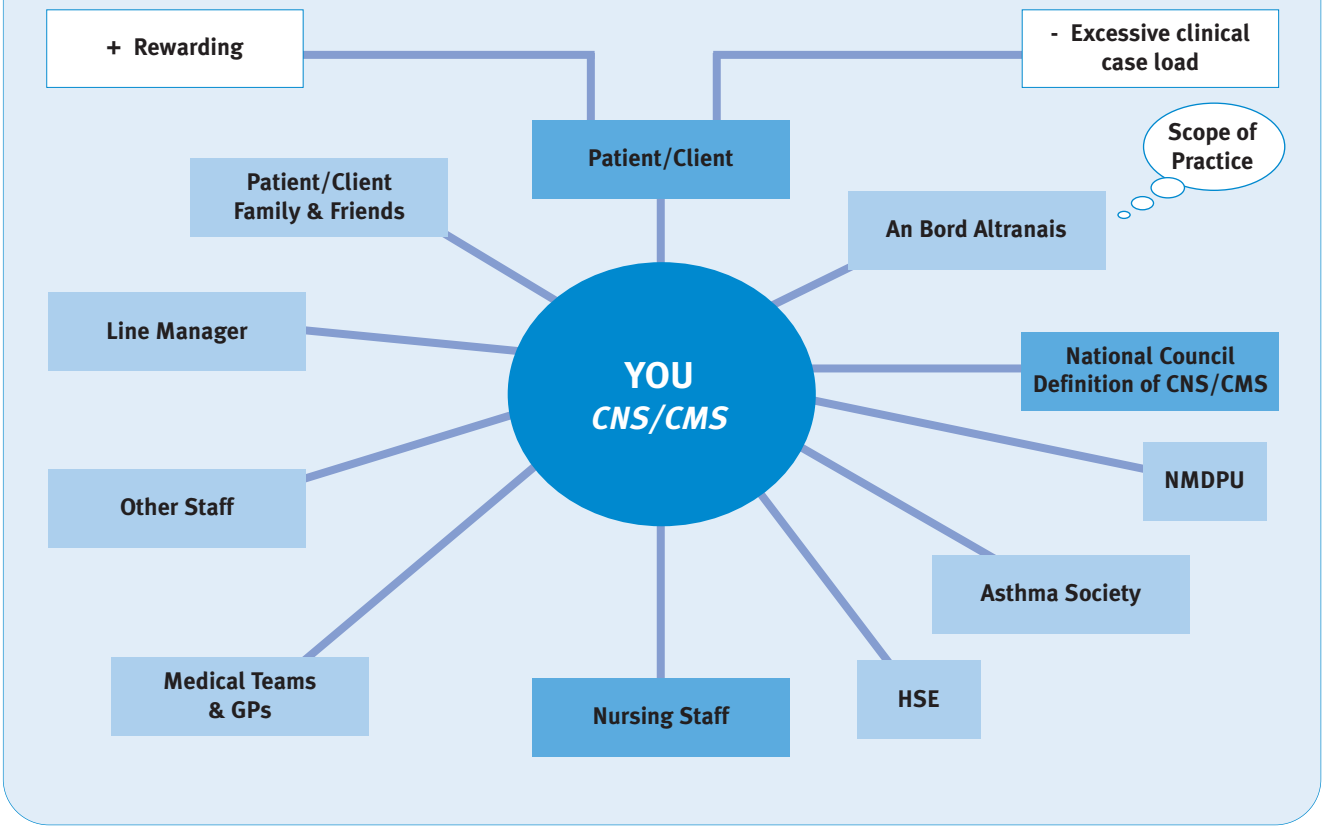
ACTIVITY 3: *CLINICAL NURSE/MIDWIFE SPECIALIST ACTIVITY/CONTACT ANALYSIS SHEET*			
CORE CONCEPT		**Time Spent** (on a scale of 0-5) 0 = no time 5 = a great deal of time	**Importance To Role** (on a scale of 0-5) 0 = of no importance 5 = of very high importance
CLINICAL FOCUS: Direct and Indirect Care			
Direct contact with patients/clients	Individuals		
	Groups		
Direct contact with nurses re patients/clients			
Direct contact with doctors re patients/clients			
Direct contact with other non-healthcare professionals about patients/clients			
Direct contact with other healthcare professionals about patients/clients			
Direct contact with relatives about patients/clients			
Telephone advice	Patients/clients		
	Healthcare professionals		
Specific health promotion activities			
PATIENT/CLIENT ADVOCACY			
Negotiating and representing individual patient/client			
	Patient/client Group		
Implementing changes in healthcare in response to patient/client need and service demands			
EDUCATION and TRAINING			
Patient/Client and Family Education			
Teaching/training other colleagues and other health professionals			
Self/Personal/Professional updating			
AUDIT and RESEARCH			
Participating in audit			
Participating/contributing to research			
Disseminating and integrating best evidence into the area of specialist practice			
Contributing to service planning/budgetary processes			
CONSULTANT (Inter- or Intra-disciplinary)			
Internal consultations			
External consultations			
Development of clinical standards and guidelines			
OTHER ***activities; ideally you should link most activities to a core concept i.e. include in preparation time.***			
Administrative/clerical (arranging meetings, writing notes, reports, filing, photocopying, etc.)			
Travelling			

2.5 IDENTIFICATION OF KEY STAKEHOLDERS IN YOUR ROLE

To know the environment you work in and to manage it effectively you need to identify your stakeholders and work out how best to relate to them. A stakeholder is "an individual or group who has a direct specific investment in the success and well-being of an organisation" (Cornelius 2001, p378). In this situation, you can replace "organisation" with "professional role". There are many ways you may like to identify your relevant stakeholders, simply by listing them or you can represent them in a "satellite" or "network" diagram as illustrated below in Figure 2.1.

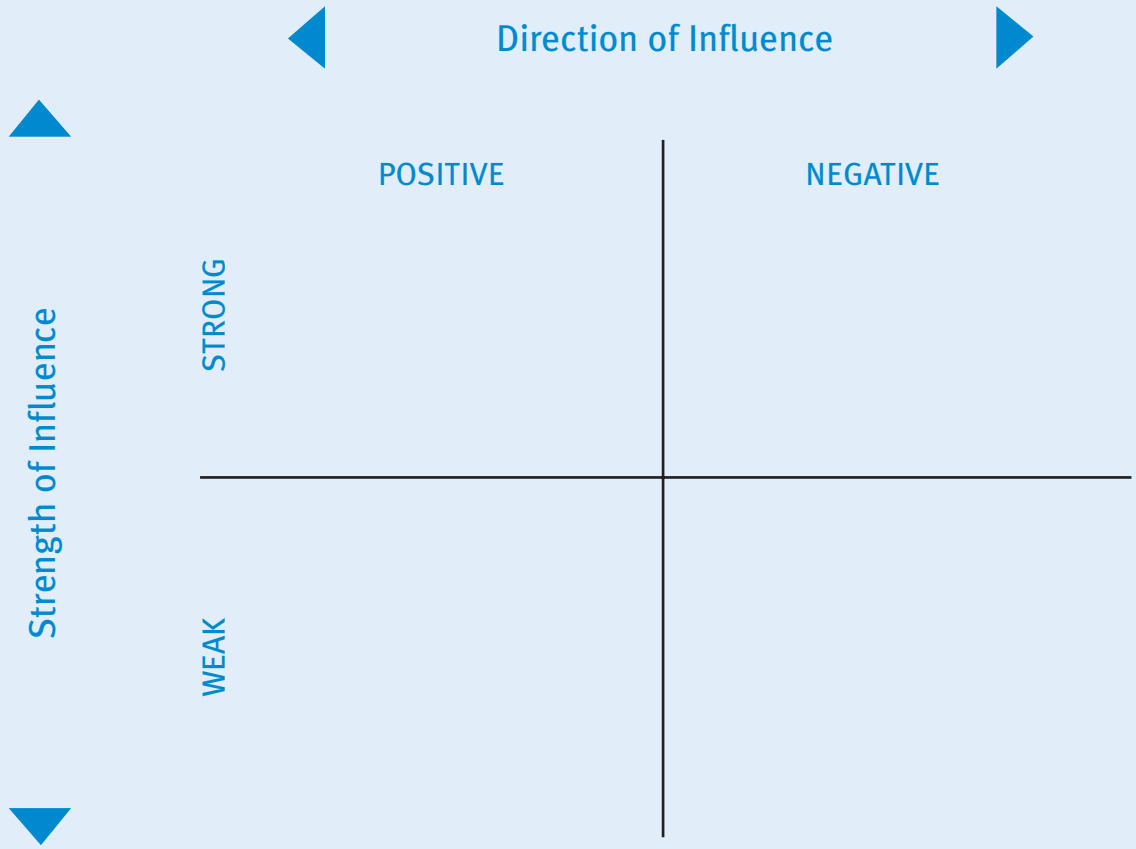
When considering your stakeholders, policies and legislation can have a significant influence on your professional role and may be considered a stakeholder. A blank copy of a network diagram is available to copy in Appendix 3 or you can sketch your own diagram on a blank page. You can vary the size, shape or colour of the "satellite(s)" to reflect their relevance to your role. You can add notes or use call out boxes from each stakeholder denoting the pluses and minuses of the relationship, for example, giving patient care may be a very positive aspect of your role, but may also be a negative influence if an excessive caseload exists. It is also important to clarify the type of influence (positive or negative), strength (strong or weak) and likelihood of them influencing you in your professional role. Figure 2.2 helps you do this.

FIGURE 2.1: A NETWORK DIAGRAM OF POTENTIAL STAKEHOLDERS FOR A CLINICAL NURSE SPECIALIST (ASTHMA)
(Adapted from *Specialist Role Evaluation Pack*, Hartley & Cowe 1997)



Having identified your stakeholders it is important to ascertain how significant each stakeholder is to you and your work. Ask yourself the following: how likely is the stakeholder to impact on the success of your role? What is the direction of their influence (supportive or competitive, i.e. positive or negative)? How strong or weak is their influence on your role? Then with the answers in mind, plot your stakeholders in the following diagram (Figure 2.2 below. A Word version of this activity is available on the CD-ROM accompanying this pack). This should help you to judge the strength and likelihood of the stakeholders influence or power in relation to your role.

FIGURE 2.2: MAPPING STAKEHOLDERS' INTEREST (Institute of Public Administration 2001)



Stakeholders affect you, whether you know it or not. Being aware of your key stakeholders guides you in your communication with them. Obviously, no stakeholder should be ignored or excluded and it is important that you are communicating with all your stakeholders. The proposed benefit of this activity is to help you priorities the frequency and urgency of your communications. The Institute of Public Administration (IPA 2001) explains that by knowing your stakeholders and their interests, you can begin to anticipate their behaviour and adjust your behaviour accordingly. Any stakeholder that you rate as having a strong influence on your role will require careful management. It is wise for you to be aware of what leverage or bargaining power you have to counterbalance your stakeholders' control. You will be most concerned with those who have a potentially high impact (negative or positive) and also are most likely to affect your role. In the healthcare environment where collaboration and partnership are required for optimal patient care, you may often build an interdependent relationship with your stakeholders (IPA 2001). You acknowledge that you cannot be independent of them and open channels of communication to explicitly agree to join forces because of the mutual benefits for you, your patient/client group and other stakeholders.

2.6 STRATEGIC PLANNING IN THE CLINICAL NURSE/MIDWIFE SPECIALIST ROLE

Though the CNS/CMS works in an often unpredictable clinical environment, he/she is expected to carry out their role in a structured and forward-looking manner. You are expected to achieve your role purpose, apply each of the five core concepts to your role, utilise your specialist knowledge and skills in an effective and efficient manner, up-skill other staff in the general care of your specialist patient/client group; all whilst demonstrating, in your present activities, awareness of the future needs and your future vision for your role and service. To implement such a strategy, which takes into account all five core concepts of the specialist role and is supported by a realistic, robust plan, the steps in Box 2.1 are recommended. The information you have collected so far will assist you in formulating your role's plan.

BOX 2.1. STEPS IN DEVELOPING A STRATEGIC DIRECTION (USING THE DEFINITION OF THE CLINICAL NURSE/MIDWIFE SPECIALIST AND FIVE CORE CONCEPTS AS A FRAMEWORK)

1	Establish strategic direction - develop a mission statement
2	Gather information and/or stocktake - conduct a SWOT analysis
3	Analyse present situation - Critical Success Factors • Set SMART Objectives • Set outcome measures
4	Take strategic action - develop operational plans

STEP 1 - Develop a Mission Statement/Vision

Your mission statement/vision is a shared understanding and a vision of the future of your role in your specialist area. It establishes the direction and purpose of your role, and indicates the values and beliefs of your organisation and specialist area, and it lays down guidelines for the way you conduct your work. Ultimately, the mission statement/vision establishes a framework in which strategy, priorities, plans and work assignments can be developed. Box 2.2 outlines the characteristics of a mission statement/vision. This was taken from the workbook developed by Change Management Training (CMT) Ltd as part of the original education programme delivered in the original CNS/CMS role development project (see *Introduction to the Clinical Nurse/Midwife Specialist Role Resource Pack)*.

BOX 2.2. FEATURES OF A MISSION STATEMENT/VISION (Change Management Training (CMT) Ltd 2002)

Inspirational in the way it presents the future
Clear and challenging
Enduring but not rigid or restrictive
Focused, gives a sense of purpose
Future orientated, honouring the past
Guiding, provides direction, establishes guidelines, not rules

By agreeing with your key stakeholders your mission statement/vision for your role and service, you will ensure unanimity of purpose and provide a basis or standard statement that specifies your role purpose and expected level

of practice. This can be translated into objectives in such a way that quality, cost, time and performance parameters can be assessed. Your mission statement/vision should incorporate the National Council's (2007a) definition and five core concepts of the role. These are evidence-based and provide a basis and framework for benchmarking your role. Box 2.3 suggests what the contents of your mission statements should be.

BOX 2.3. COMPONENTS OF AN EFFECTIVE MISSION STATEMENT/VISION (Change Management Training Ltd 2002)

Who your *customers* are
What your services are
Your concern for continuous quality improvement
Your philosophy of care
Self-concept – Your strengths and concern for public
Concern for *employees*/others (demonstrate your attitude towards other staff)

The steps involved in reviewing an existing mission statement/vision (Appendix 4 - Option 1) or formulating a new mission statement/vision (Appendix 4 - Option 2) are provided by Change Management Training (CMT Ltd 2002) as a template for you to develop your own mission statement.

STEP 2 - Gather Information/SWOT Analysis

SWOT or TOWS analysis (depending on which way you wish to approach it) is a particularly useful technique to gain insight into your role and your overall performance in your specialist area. The SWOT analysis must take into account both the internal and external environment in which you work. The strengths, weaknesses, opportunities and threats will be factors identified by you in relation to your role purpose. Gather information from a variety of sources, e.g., patients/clients, line manager, clinician(s), other specialists and the nursing/midwifery literature relevant to your specialist area. If you find this exercise difficult to do alone, try pairing up with a colleague. This exercise may also raise issues that require liaison with your manager or a relevant clinician to discuss and possibly resolve. The questions in Activity 4 are some suggestions from the *Specialist Nurse Role Evaluation Pack* (Hartley & Cowe 1997) and you may be able to identify more questions applicable to your individual situation. To complete this exercise use a blank sheet or a page divided into quarters to answer the questions. The information already gathered in previous exercises - key performance areas and activity analysis - can help you to identify areas in which you are doing “less well” than you might wish and which you may like to address in the future. Identified factors to consider may include your caseload activity, the level of autonomy you have and the decision-making processes involved in your specialist area. Remember to identify aspects of your role in which you are excelling in and may wish to maintain in the future.

ACTIVITY 4: *SWOT ANALYSIS* (Adapted from Hartley & Cowe 1997)	
S	**Strengths** What are the best aspects of your service and the care you give? What positive feedback have you had? Does your role fit in well with the National Council's (2007a) definition and demonstrate integration of the five core concepts into your role? What are you proud of? What do you think you are most valued for (by patients/clients/other users of your service, by your manager)?
W	**Weaknesses** What are your concerns about the service you provide? Do colleagues have a poor understanding of your contribution? What are the difficulties organisationally in delivering your service? What criticisms could patients/clients/other consumers/managers have, or what, if any complaints are you aware of?
O	**Opportunities** How could your patients benefit by developing your services? Are there clients, who could benefit from your service that you are currently not reaching? What innovative ideas have you had? What has been identified at any performance reviews relating to you/your role?
T	**Threats** Where are changes in other parts of the service affecting your work, i.e. changes internal/external to your work and organisation? Where do you sense there is lukewarm support for, or even opposition to, your work? Are there issues/problems with your funding? Is changing skill mix affecting your work?

A Word version of this activity is available on the CD-ROM accompanying this pack.

STEP 3 - Analyse Your Present Situation - Critical Success Factors

What are the critical success factors needed to achieve your goals and perform in each key performance area? The five core concepts are main components and key performance areas of your role. When all concepts are operationalised/applied to your role, they increase your likelihood of succeeding in delivering an effective, appropriate specialist service for your patient/client group. Your critical success factors are the current factors (internal and external to you) that make it feasible to operationalise the core concepts of your role. The easiest way to identify what your critical success factors are is to ask yourself the following question: “From a customer's viewpoint, what are the main things I have to do right to succeed?” (CMT Ltd 2002). You may wish to approach this by looking at critical success factors under each core concept. The answers you provide in each area will identify what you need to accomplish or focus on if your mission statement/vision is to become a reality.

These factors, particularly those you can influence, can later become objectives for your strategic plan (Step 4). When you have identified your critical success factors, carry out a self-assessment to identify your developmental need in each factor. Rate yourself on a scale of 1 to 6, where a score of 1 indicates that you are very poor in that area and 6 means that there is no room for improvement. A Word version of this activity is available on the CD-ROM accompanying this pack.

ACTIVITY 5: CRITICAL SUCCESS FACTORS (CSF)		
Using the five core concepts as a framework, list below what you believe are the critical success factors	Order of Importance (1-5)	Self-assessment rating on a scale of 1 to 6 with 1 indicating greatest learning/improvement need and 6 indicating no improvement/learning need.
1. Clinical Focus		
2. Patient Advocacy		
3. Education and Training		
4. Audit and Research		
5. Consultancy		

Critical success factors should be linked to the goals which your specialist area or organisation aim to achieve over a given period of time. Using the five core concepts as a framework allows you to develop a plan in all aspects of your role. Step 4 assists you to set objectives for your high priority critical success factor(s), under each of the five core concepts. Start with those success factors from Activity 5, where you identified the greatest development need.

STEP 4 - Set SMART Objectives

Objectives for your role are necessary to be able to define what is to be achieved in a given timescale. To ensure that an objective is effective, use the SMART acronym:

Specific

Measurable

Achievable/Agreed

Relevant/Realistic

Time-bound

To set your objectives, take your priority critical success factors (CSF), i.e. the factors where you have identified the greatest development need and consider where you would like to be in five years with this CSF. Form a vivid picture for yourself of what things will be like in five years' time for this success factor. Then set SMART objectives for the short-, medium- and long-term (over the next six months, year and two to three years respectively) for each priority CSF in every core concept area. Time frames for short, medium and long terms given are just guidance and you may want to adjust them to reflect your service and expected rate or need for change. What is important is that your objectives are time-bound which supports review of your objectives. Below are the objectives of Mary, the CNS (Asthma) in our case study. (Other case studies are available on the CD-ROM accompanying this pack.)

CASE STUDY: MARY - CNS (ASTHMA)

Examples of short-term **SMART** objectives for Mary:

1. Clinical Focus	**Direct care:**	By the end of the year, set up an OPD nurse-led clinic to follow up children newly diagnosed with asthma attending St Blanaid's
	Indirect care:	By the year- end establish a 7-day week (8am - 6pm) nurse-led telephone support/help-line service for parents of children newly diagnosed with asthma
2. Patient Advocacy - on an individual or group basis		
	Group Advocacy:	To represent the needs and values of asthmatic patients at the quarterly departmental service review meetings
3. Education and Training - self, patient or staff		
	Staff:	To represent the needs and values of asthmatic patients at the quarterly departmental service review meetings
4. Audit and Research	**Audit:**	By the end of the year, to carry out a patient/client satisfaction survey about the care received from me during their OPD contact
	Research:	The nurse-led children's clinics that I have implemented and evaluated in OPD will be based on the “best in class” practice. I will develop guidelines for the clinic based on same I will contribute to research by informing relevant persons of any emerging issues that may be relevant for future research
5. Consultancy - inter- and intra-disciplinary		
	Intradisciplinary:	By the end of the year, to disseminate to relevant clinical areas within St Blanaid's updated clinical practice guidelines on asthma care
	Interdisciplinary:	I will also update the referral pathways to my CNS services and communicate same, with my phone number, to healthcare staff in the hospital and the community indicating my availability for consultation regarding asthma care in order to improve patient/client management

Steps involved in setting objectives:

If one of your priority critical success factors was to provide person-centred holistic care to all patients/clients, consider where you expect to be in five years' time in relation to this success factor. Form a vivid picture in your mind of what things will be like in five years for this issue. Then come back from that clear picture in the future to today and consider the steps that will be required to achieve that vision of the future. First, identify what needs to be done in the next six to twelve months if this success factor is to move closer to that five-year place. Then, you can decide what you need to do in the medium- and long-term to achieve your long-term, five-year objective in this success factor.

Write a robust statement that outlines your objective and meets the SMART criteria. Select the most important factor you need to address in an agreed "review period" or in the next twelve months. Initially, this may include a short-term objective of developing your knowledge of "person-centred care". Next consider what exactly you are going to do in this review period to improve your knowledge of this critical success factor. Your SMART objective might read as follows: "I shall have read five peer-reviewed, evidence-based articles on person-centred care by December 2008."

The short-, medium- and long-term objectives should show development along a continuum of initiation, implementation and evaluation in the attainment of your five-year objective. In this example, you have a short-term objective of increasing your knowledge of person-centred care by reading evidence-based literature on the topic over the next few months. A SMART medium-term objective could be: "Within the next twelve months, I will pilot and evaluate a six-month programme to introduce individualised care plans for asthmatic patient/clients that I see on Ward B". A long-term objective could be "to establish and evaluate a person-centred care pathway for all asthmatic patients/clients who are admitted via A&E to the medical wards by December 2010". Appendix 5 provides a template to write your own objectives (CMT Ltd 2002): one copy is required for each critical success factor. A Word version of the templates is available on the CD-ROM accompanying this pack.

STEP 5 - Set Outcome Measures for Each Core Concept

How are you going to measure the success of your role and the achievement of your objectives? It is important to define the outcomes you expect from your role and indicate clearly all the significant factors that determine success, i.e. what will you define success as/how you will know you have achieved your objectives. Consider the "what if" factors from the onset as your outcomes should not be open to misinterpretation and again should be SMART. In your strategic plan, your outcomes may be service outcomes, patient/client clinical outcomes or your own professional development outcomes.

The factors to be considered when setting outcomes usually include time, cost, quality and quantity. Pairing up with a colleague, manager or clinician will help you set agreed outcomes for your strategic plan. Chapter 7 in *Quality and Fairness - A Health System for You* (DoHC 2001) details the national health strategy action plan relating to each of the national goals. Review these actions to see which relate to you and your service. Assess whether this action should be an expected outcome for your role, or whether any of your present outcomes directly relate to an action. Now is also a good time to view best practice sites and documents to see if there are any pre-set performance indicators from *Quality and Fairness* or clinical benchmarking that you can use when deciding your role outcomes under each core concept. In 2002 National Project Teams and the DoHC developed a set of sixty-eight performance indicators covering eleven "care groups". These care groups cover Health Promotion, Overall Health, Primary Care, Acute Services, Ambulance Services, Mental Health Services, Child and Adolescent Services, Child Care, Older Persons, Disability Services and Social Inclusion. For a more up-to-date identification of care groups and service aims, you could look at the HSE's current service plan.

Performance indicators (PIs) identify the output (end result) that must be attained and become targets or performance milestones to be reached by individuals or organisation. Measurement of your practice against these indicators highlights performance. By monitoring trends in performance you can see at a glance whether objectives are being met or if plans are going awry. By using pre-set, evidence-based PIs you can compare your practice and role against peers. Through benchmarking, you can see possibilities, diagnose shortfalls in performance, as well as aid feedback in a continuous quality improvement approach. Visit www.beacon.nhs.co.uk to view any benchmarking sites

or practices of interest to your specialist area. The National Council's preliminary evaluation of the CNS/CMS role (National Council 2004b) also identifies key outcomes CNSs/CMSs may wish to measure as an indicator of the success of their roles and how they are performing in each core concept/key performance area.

Chapter 4 *(The Clinical Nurse/Midwife Specialist and Audit and Research)* deals more specifically with measuring, audit and evaluation and provides examples of outcomes for Mary, the CNS (Asthma) in our case study, that may provide you with useful ideas for outcomes associated with your role. The following explains the components of a SMART outcome, outlining the measures or milestones that Mary could use to demonstrate how a previous audit objective is being achieved. How the objective is to be measured is clearly stated. An evidence-based definition of what is considered a "high level" of satisfaction and reference to the type and frequency of the audits should be clarified and agreed within the outcome definition. This covers any "what if" situations. Other case studies are available on the CD-ROM accompanying this pack.

CASE STUDY: MARY - CNS (ASTHMA) *EXAMPLE OF SMART OUTCOME MEASURE*

A SMART outcome for the short-term "audit objective" regarding the CNS carrying out a patient satisfaction survey could be:

"There is an evidence-based patient satisfaction survey tool, appropriate to patients/clients attending a CNS service, developed and implemented in OPD within the first three months of the clinic being set up."

A standard statement, based on best in class evidence, outlining the expected level of satisfaction is developed within the first three months of the clinic being set up.

By the end of the year, documented evidence of ongoing audit of patient satisfaction surveys against this agreed standard is available.

By the end of the year, action plans are in place to address aspects where poor performance identified.

By the end of the year, results demonstrate a high level (>80%) of patient/client satisfaction with the care received from the CNS in the OPD setting.

STEP 6 - Taking Strategic Action

The final step in developing a strategic plan for your role is to write a systematic, holistic plan detailing how you will achieve each of your objectives and outcomes that you have been set to date. This is known as an outline or operational plan. It is vital this planning identifies all of the issues such as resource requirements, interim deadlines/review dates, people responsible, and performance indicators/outcome measurement. Time spent on the planning stage will reap rewards.

Having completed Steps 3, 4 and 5, the individual tasks required to achieve your objective should now be fairly evident to you. Appendix 6 contains a template for completing an outline or operational plan. Identify responsibility for each stage and how you will measure progress throughout the duration of the objective. This is written down under the headings of responsibility and performance measurement indicators. Quality is addressed if the process involves reviewing the literature and benchmarking practice; these should also be referenced in your outline plan as appropriate.

Below is the outline plan of Mary, the CNS (Asthma) in our case study. (Other case studies are available on the CD-ROM accompanying this pack.)

CASE STUDY: MARY - CNS (ASTHMA) *OUTLINE/OPERATIONAL PLAN FOR PREVIOUS AUDIT OBJECTIVE*

Business Plan Reference: Corporate Plan

Operational Plan reference: St Blanaid's Asthma Service

Key Priority:
Mary surveys a random selection of ten patients each month who attend her OPD clinic for children newly diagnosed with asthma.

Actions to be taken to implement this priority
She uses a validated or best in class tool to elicit patient/client and parent satisfaction with the nurse-led clinics. The data is collated regularly every second month, the results communicated to relevant persons, and an action plan implemented to correct any deviations from the norm or best practice as necessary.

Who will be responsible for its implementation?
Satisfaction tool will be agreed by multidisciplinary team and managers.
CNS (Asthma) will manage satisfaction surveys and compile report.
Secretary will input ten completed surveys a month into an Excel spreadsheet.

Identify funding source:
From existing resources - internal surveys at point of service thus there are no postal costs. Human and financial costs as to cost of printing and collating the questionnaires and/or cost of four hours per month of Mary's and the secretary's time protected for carrying out audits are not being costed as these will be taken from within current working hours.

Measurement criteria/performance indicators
Patient/client and parent satisfaction with service measured on a continuous monthly basis

Satisfaction with the environment of care, facilities and services as well as information provided and level of courtesy, care and dignity received will be measured.

Review dates: This priority will be reviewed every three months from now, e.g., 12th December 2008; 12th March 2009, etc. The first survey is due for completion by December. A report will be written and disseminated to relevant personnel at this stage; meetings and an action plan to address any necessary improvements will be agreed by end of March 2009.

Continuous re-auditing of patient/client satisfaction will be ongoing throughout the year unless it is agreed by the team such a process no longer required

In summary, your finalised strategic plan for your specialist role should use the five core concepts as a framework, follow a step-by-step approach and reflect best practice.

If all the steps are covered you will have an effective plan. This strategic planning process will also be useful for any future service or business plan in which you may be involved. Box 2.4 below contains a summary of suggested headings for your overall strategic plan document which brings together of all the steps addressed previously in this chapter.

BOX 2.4. SUGGESTED OUTLINE FOR A CLINICAL NURSE/MIDWIFE SPECIALIST'S STRATEGIC PLAN

Background to your role/your service, outlining where you are now
Mission statement for your role
Strategic objectives for your role, outlining where you want to be in the future under each core concept to the role
Outcome measures in terms of time, cost and quality
Outline/operational plan to outline changes which are required to make your plan work, how performance will be measured and review dates

"Strategy is the route that has been chosen for a period of time and from a range of options in order to achieve goals" (Harrison 2000, p80).

CHAPTER 3

Competency Review and Personal Development Plans

3.1 INTRODUCTION

Chapter 2 of the *Clinical Nurse/Midwife Specialist Role Resource Pack* was primarily concerned with reflecting, clarifying and planning for the future of your role and specialist service. It involved self- and peer-assessment of the activities you do in order to achieve your role purpose. Chapter 3 of the resource pack asks you to reflect on the competencies required of you to carry out the activities within the core concepts of your role.

Chapter 3 will enable you to:

- Assess your own development needs in each of the competencies you identify for your role
- Create a personal development plan
- Commence a personal and professional portfolio.

An Bord Altranais (2000) defines competence as "the ability of the registered nurse/midwife to practise safely and effectively, fulfilling his/her professional responsibility within his/her scope of practice." The common components and attributes of a competent person in nursing were collated by the Australian Nursing Council and are cited in the Irish *Scope of Practice* document (An Bord Altranais 2000, p21). They include:

- Practical and technical skills
- Communication and interpersonal skills
- Organisation and managerial skills
- The ability to practise safely and effectively, utilising evidence-based practice
- Having a problem-solving approach to care, utilising critical thinking
- Being part of a multidisciplinary team and demonstrating a professional attitude
- Accepting responsibility
- Being accountable for one's own practice.

Many of these competencies can be adapted for specialist practice or you can discover more competencies specific to your specialist area by searching the nursing and midwifery literature for reviews of similar specialist roles.

3.2 COMPETENCIES OF THE CLINICAL NURSE/MIDWIFE SPECIALIST

The National Council has provided a definition of a CNS/CMS, outlined the underlying core concepts and indicated the desired level of knowledge, experience and abilities of this specific group of professionals (2007a). The criteria for the post-holder include the requirement for the post-holder to have extensive experience and clinical expertise, to be competent, to demonstrate evidence of continuing professional development and to have undertaken post-registration education at Level 8 or above on the National Qualifications Authority of Ireland's qualifications framework (or to have given contractual agreement to do so) (National Council 2007a).

While core competencies have been formally identified for the CNS/CMS (see Box 1.6, Chapter 1), it is the service's role to identify the specific competencies that will enable the post-holder to meet the service's particular needs. There is ample international nursing literature referring to the wide range of knowledge, skills and attributes necessary for a CNS/CMS and/or associated with positive outcomes in the CNS/CMS role. Marshall and Luffingham

(1998) list generic core competencies devised by forty-three specialist nurses in a UK trust, under the headings of clinical focus, educator, researcher and change agent. Roberts-Davis and Read (2001) in their research on the similarities and differences between nurse practitioners and CNSs in the UK, discuss the domain of nursing and managerial skills that are part of the CNS role. Armstrong (1999) and Chuk (1997) studied the range of CNS roles in the UK and in doing so, listed some of the expected skills and competencies in each sub-role, many of which are mentioned in Chapter 2 of this resource pack.

Bousfield's (1997) study into the experiences of the CNS in the UK discusses barriers and enablers to the CNS role and in doing so, highlights some key competencies of the CNS role: leadership skills, expert knowledge, time management skills, role evaluation skills and empowerment of self and others. Cattinni and Knowles (1999) describe a framework, devised by a group of CNSs in an acute NHS trust hospital, for assessing the five key roles of the CNS using core competencies. The five key roles identified were: "to be the acknowledged nurse expert in a specified clinical subject within the trust; to be the major source in the trust of current research-based practice in their specified subject; to provide professional support and back-up to staff and patients in the clinical field which they are an acknowledged expert; to manage their individual workload effectively; to be an effective communicator" (Cattini & Knowles 1999, p508).

Each key role has a designated standard of competency that can be measured via the "mode of achievement". Cattini and Knowles (1999) also discusses Waller's (1997) "X Factor" in specialist nursing practices. The features of the "X Factor" include expert problem-solving skills, recognition of changing professional boundaries, flexible cross-boundary working and the capacity to bring about change. Davies and Hughes (1995) when discussing the characteristics and competencies of advanced nursing practice identified eight areas of competence, which included clinical expertise; critical thinking and analytical skills; clinical judgement and decision making; leadership and management; communication; problem solving; collaboration; and education and research. The National Council's *Evaluation of the Effectiveness of the Role of the CNS/CMS* (2004b) reviews international literature and identified many outcome performance measurements specialists have been involved in. These and the research findings around the qualities of a CNS/CMS provide specific ideas for a CNS/CMS to review their individual need for competency attainment, e.g., establishing and monitoring nurse-/midwife-led services, monitoring and measuring clinical and non-clinical outcomes of care and research utilisation.

Another source of competencies for the CNS/CMS is your job description/profile. A current job description should outline your role and responsibilities but also list the competencies required for the role. This is often found in the "job specification" section.

The Office for Health Management (OHM), following the recommendations of the Commission on Nursing (Government of Ireland 1998), identified management competencies for nursing and midwifery management positions (OHM 2000). Each competency is linked to "behavioural indicators". Widely researched, many of the

BOX 3.1: NURSING MANAGEMENT COMPETENCIES (Office for Health Management 2000)

GENERIC	FRONT-LINE LEVEL
Promoting evidence-based decision making	Planning and organisation of activities and resources
Building and maintaining relationships	Building and leading the team
Communication and influencing relationships	Leading on clinical practice and service quality
Service initiation and innovation	
Resilience and composure	
Integrity and ethical stance	
Sustained personal commitment	
Practitioner competence and professional credibility	

generic and front-line manager competencies also apply to the CNS/CMS role. These are listed in Box 3.1.

You can complete a self-assessment on-line by visiting the HSE's Learning Centre website (www.hseland.ie). Peer and managerial assessment on-line and a guide to developing a personal plan are also available. This is a free service. When you collate your scores, your results are categorised into varying degrees of developmental need. A word of caution: remember that these tools are aimed at nurse/midwife managers rather than at those people who are following a clinical career pathway. The five core concepts are an appropriate framework for the identification of the competencies required for your role. Reviewing your competencies under each concept will safeguard you from omitting competencies applicable to any particular component of your role.

In brief, to identify the competencies required for your specialist role, it is recommended that you search the literature relevant to your specialist area and review your job description. It is necessary that the CNS/CMS identifies his or her own continuing professional development needs and engages accordingly. (It is suggested that you read *Building a Culture of Patient Safety*, DoHC 2008, particularly the discussion of accountability.) This is so that he/she can maintain competence and clinical credibility and fulfil patient/client, professional and service expectations. Keeping up to date is not an easy task and access to required educational opportunities and study days is not always available to every CNS/CMS. To overcome this, the development of a personal development plan provides you with a powerful tool to identify the educational opportunities you require. If agreed with your manager, it is more likely to succeed.

3.3 STEPS IN FORMULATING A PERSONAL DEVELOPMENT PLAN

A personal development plan (PDP) is considered a useful tool to help individuals plan and meet their development needs. Armstrong and Baron (1998) wrote that PDPs should include:

- An assessment of the person's current position which identifies development needs and wants and the means of satisfying these
- Setting goals using performance headings such as improving or acquiring skills, extending relevant knowledge or developing specified areas of competence
- An action plan outlining what needs to be done and how it will be done
- Setting dates for evaluation and review.

BOX 3.2. PERSONAL DEVELOPMENT PLANNING (Pedlar, Burgoyne and Boydell 1978)

1. Self-assessment -	following individual careful analysis of their work and life situation, rating oneself in each area of the job
2. Diagnosis -	identification of learning needs and their prioritisation.
3. Action planning -	identification of objectives, aids and hindrances to action; the determination of resources (including people) needed to carry out the action plan; and an agreed timescale.
4. Monitoring and review -	monitoring and review processes must be determined, and a timescale established for those processes to take place

To become a reality, a PDP needs support. Newcomers to a job or role should formulate PDPs at an early stage. This should occur with assistance from a manager and a mentor (the two should be different). To be of value, your PDP should be regularly updated and take account not only of your professional development needs and your personal ambitions, but also of the requirements of your practice, service plans, local developments and other relevant

agendas. If you have not already done this, use this opportunity to agree with your manager that your PDP will become a shared document that you both agree and regularly review. Pedlar, Burgoyne and Boydell (1978, cited in Harrison 2000, p353) recommend four stages in developing a PDP (Box 3.2). (For a more up-to-date Irish guide, you can still download the Office for Health Management's *Personal Development Planning Guidelines and Workbook* (2003) from www.hseland.ie.)

STEP 1 - Self-assessment

Following careful analysis of the literature, your individual work and life situation, your job description and the definition of the CNS/CMS role, outline in Activity 6 below what you feel are the key competencies that you require to be effective in your position. Once you have identified the competencies, decide on their order of importance (relative to your role) and briefly indicate why you think the competency is important to your role. (A Word version of this activity is available on the CD-ROM accompanying this pack.) The five core components of your CNS/CMS role are suggested headings under which to review your competency needs.

STEP 2 - Diagnosis

Write out the competencies you identified in order of importance in Activity 7. (A Word version of this activity is available on the CD-ROM accompanying this pack.) Make a note of your current level of competence/ability for each of the ten or so competencies you have prioritised as important to your role. To assess your level of competence, reflect on how well you are achieving in relation to the competency and then score your ability, using a scale of 1 to 10. Score yourself a "10" if you feel you have no room for improvement and a "1" if you feel that you do not display this competency at all. You decide. The last column asks you to briefly state the actions that you will take to address any development needs you may have identified.

If all the actions aimed at addressing your development needs involve attending formal education and training programmes, you may need to apply some lateral thinking. Are there any other ways you can gain the necessary experience, knowledge, skills and attitudes? Box 3.3 provides a list of some common learning strategies; more can be found in the National Council's *Guidelines for Portfolio Development for Nurses and Midwives* (2006a).

BOX 3.3: COMMON LEARNING STRATEGIES (Adapted from CMT Ltd 2002)

1. On-the-job or in-service training
2. Library
3. One-to-one coaching by relevant personnel
4. Additional assignments
5. Rotational assignments
6. Readings in books and journals
7. Cross-training
8. Shadowing another performer
9. Visits to other sites
10. Correspondence courses
11. Evening classes
12. Computer assisted programs
13. On-line courses
14. Formal training courses
15. Staff instructions and circulars
16. Peer supervision/feedback/evaluation

STEPS 3 and 4 - Action Planning and Monitoring and Review

Appendix 7 provides you with a template to complete a personal development plan for each competency (CMT Ltd 2002). Start with the competencies you ranked as having the highest priority and assessed as needing significant improvement. Answer each section. You are the driver, i.e., the one in control, and responsible for this plan but to ensure that the plan becomes a reality, elicit the support of your manager and/or mentor in agreeing, monitoring and reviewing the plan within a specified timeframe. Knowledge and maintenance of a competence is not static, therefore your PDP should be revisited on a regular basis to monitor and re-assess your competence level. This will identify areas that may require re-visiting or further attention in response to emerging patient/client, service, personal or professional needs.

ACTIVITY 6: IDENTIFYING AND PRIORITISING COMPETENCIES REQUIRED FOR YOUR ROLE		
COMPETENCY	**IMPORTANCE RATING**	**BRIEFLY, WHY IS IT IMPORTANT?**
CLINICAL FOCUS		
PATIENT/CLIENT ADVOCACY		
EDUCATION AND TRAINING		
AUDIT AND RESEARCH		
CONSULTANCY		

ACTIVITY 7: SELF-ASSESSING YOUR LEVEL OF COMPETENCE (CMT Ltd 2002)			
Priority	**Competency Description**	**Level (1-10)**	**Actions that I could take to address my development need**

Opposite is an example of a personal development plan for Mary, the CNS (Asthma) in our case study. (Other case studies are available on the CD-ROM accompanying this pack.)

CASE STUDY - MARY, CNS (ASTHMA) *EXAMPLE OF PERSONAL DEVELOPMENT PLAN* (Adapted from CMT Ltd 2002)

(ONE PLAN PER COMPETENCY/DEVELOPMENT NEED)

Competency: Evidence-based decision-making

Related Core Concept: Clinical Focus (Direct and Indirect care) and Research Utilisation

Target Outcome: A clear description of what I will be able to do, once I have addressed the competency.

I shall make decisions in a judicious and timely manner, considering all relevant information when addressing a problem or issue in a clinical or professional area

I will use logical analysis to break down complex problems into their component parts and question my approach to care/the solution

I will find and appraise relevant literature to my area of speciality

I will apply research findings/evidence-based knowledge to improve nursing practice

I will assess if nursing care has improved because of the actions applied

Specific Steps that I will take to address this particular development need, including the date steps to be completed by

Steps I will take:	**Expected Completion**
Update my knowledge of problem-solving, critical analysis/appraisal and factors influencing decision-making in clinical practice	In 1 month's time
Practise using analysis and logic in my problem-solving approaches - differentiating critical elements from minor ones and consulting widely with others to ensure solutions are based on the "full picture" - all available information, the best in class evidence, my clinical expertise and patient/client values	Practise for 3 months, then ongoing
Based on evidence, generate a number of options, have a plan B and intervene appropriately	Practise for 3 months, then ongoing
Allocate 1 hour a week as "Library Time" to update myself on best available evidence relevant to my practice	Practise for 3 months, then ongoing

How will I measure my success?

1. I have updated my knowledge of problem-solving, critical thinking and decision-making and also have sound knowledge of my organisation's policies and procedures
2. I can demonstrate the promotion of evidence-based decision-making in my practice (seen in my activity analysis diary, any reflective, critical analysis I document and any audit of outcome performance measurements I do)
3. I demonstrate awareness of complex problems in my specialist area

Ways I will be able to utilise this competency

- Clinical decision-making in relation to patient/client care - to reflect the level of decision-making required of a CNS/CMS
- Decisions regarding service needs and developments
- Decisions regarding professional career matters
- Part of the CNS role is to promote the use of researched, evidence-based practice. I can promote this by being a role model in research utilisation and contributing to nursing research where appropriate. This sub-role also requires decisions to be made regarding changing practice at ward level and thus require me to have knowledge and skills in this competency

Support I will need to develop this competency - whose support do I need and how will I obtain it?

- Access at work to library and internet
- Schedule times in diary, book in advance internet/reading room when required
- Access to organisation's up to date policies, protocols and guidelines
- Ask nurse manager or nurse practice development co-ordinator/facilitator if there is an updated list
- Support from my manager and clinical team to allocate one hour a week to "library time" and also to support my decision-making processes and at times decisions
- Discuss with relevant staff

Cont.

◀ Cont.

How will I measure my progress?

Evidence of:

- Increased body of knowledge of problem-solving, critical analysis and decision-making
- Ability to articulate the theory behind my decision-making processes
- Evidence-based decision-making in my clinical and professional practice
- Critical incident analysis maintained
- Adherence to library time
- Adherence to review of this PDP

Review Dates: May, September and November 2008

Signed: CNS/CMS	**Signed: Nurse Manager**
Mary O'Brien, CNS (Asthma), St Blanaid's	Maire Malone, Asst Director of Nursing, St Blanaid's; 01/01/2008
Date: _____	Date: _____
Date: _____	Date: _____

3.4 PORTFOLIO DEVELOPMENT

When used by nurses and midwives a portfolio is generally understood to be an organised collection of documents chronicling an individual's career: these documents may then be drawn upon when applying for jobs or courses, or in order to demonstrate learning (National Council 2006a). The National Council has published guidelines for portfolio development that are particularly useful in the in the context of the Irish health service (*Guidelines for Portfolio Development for Nurses and Midwives*, National Council 2006a).

A profile is select information drawn from your portfolio for a specific public purpose, thus you could have a series of profiles for a variety of purposes from accreditation of prior (experiential) learning (APL/APEL); interviews; curricula vitae; individual performance review (IPR) and career planning. A study undertaken in the UK (Richardson 1998) when profiling was recommended for renewal of NMC registration found profiling was underused by nurses; but of those who did use it, the sections most commonly used when profiling were: recording personal details, study days, qualifications, critical incidents and reflection.

The benefits of using portfolios include development of self-awareness, reflective practice and planning for the future. To develop a portfolio you need to answer some of the following questions in relation to your professional life: Where have I come from? Where am I now? Where do I want to be? How am I to get there? Having most of this information gathered already, it would be opportune to provide a format and structure for saving this information.

Once developed, your portfolio will be simple to maintain over the years. Each portfolio will be different and it is important it represents “you”. The National Council's guidelines for portfolio development (2006a) suggest the materials and system below for organising your portfolio (Box 3.4). It links in well with what we have covered to date in the resource pack and there are some added tips and suggested references to assist you in this exercise. Please note portfolios used for academic purposes are often quite different and you should consult the academic institution concerned for guidance on what they are specifically looking for.

What you need to get started:

1. A sturdy portfolio ring-binder-folder

2. Plastic page holders

3. Tabbed dividers to create distinct sections

4. Forms to help you organise or reflect upon learning situations

5. CD-ROM or memory stick for electronic records, if preferred.

Collect everything that you think may be useful or relevant and then, when putting the portfolio together, you can choose what you actually need.

BOX 3.4. SUGGESTED OUTLINE FOR A PORTFOLIO
(Adapted from *Guidelines for Portfolio Development for Nurses and Midwives*, National Council 2006a)

SUGGESTED SECTION TITLE	SUGGESTED CONTENT
Personal information	Name (as on birth certificate and An Bord Altranais registration certificate) Home address Telephone numbers Fax number An Bord Altranais PIN Divisions of Register (Irish and non-Irish) in which name is entered Date of registration in division(s) of Register (Irish and non-Irish)
General Education	Second-level school(s) and/or college(s) attended Third-level and further education colleges attended, courses undertaken and qualifications obtained (including non-nursing and non-midwifery courses and qualifications)
Professional Nursing/Midwifery Education and Training	Registerable qualifications obtained Details of school(s) of nursing/midwifery attended and courses undertaken
Professional Nursing/Midwifery Posts Held	Chronological list of all posts held including title of post, employer's details, dates of employment, main responsibilities and duties
Employment outside Nursing/Midwifery	Chronological list of all posts held including title of post, employer's details, dates of employment, main responsibilities and duties
Continuing Professional Development	Personal development plans and performance reviews Clinical supervision records Study activities Research, audit and project work Documents written, co-written, etc Lectures, seminars, papers and posters presented In-service training completed Conferences and seminars attended Membership of professional associations and organisations

The National Council's guidelines (2006a) also contain suggestions for items and documentary evidence you might include in your portfolio, as well as sample forms which are available in Word version on the CD-ROM that accompanies the book. In addition, you might wish to include the following items or sections.

A Statement of Your Philosophy of Nursing

This statement(s) should reflect your belief and values about nursing. You could use your mission statement or information from it here. You could use the features and methods for developing a mission statement (Chapter 1) to develop your philosophy of nursing.

A Curriculum Vitae and Résumé

It is always wise to keep an up-to date curriculum vitae (CV). There are lots of books, articles and websites that can

assist you in developing and presenting your CV. Further information on preparing for competency-based interviews (including developing a CV) is available on line from www.hseland.ie or other career development websites.

Samples of Your Work

Concentrate on samples which best demonstrate the different skills and abilities you possess. Some things you might include are: job descriptions; copies of presentations you have made; list of committees you belong to and a statement about their activities (if not included in your CV); research proposals and reports; projects you have completed and copies of publications or articles you have written.

Records of Previous Learning

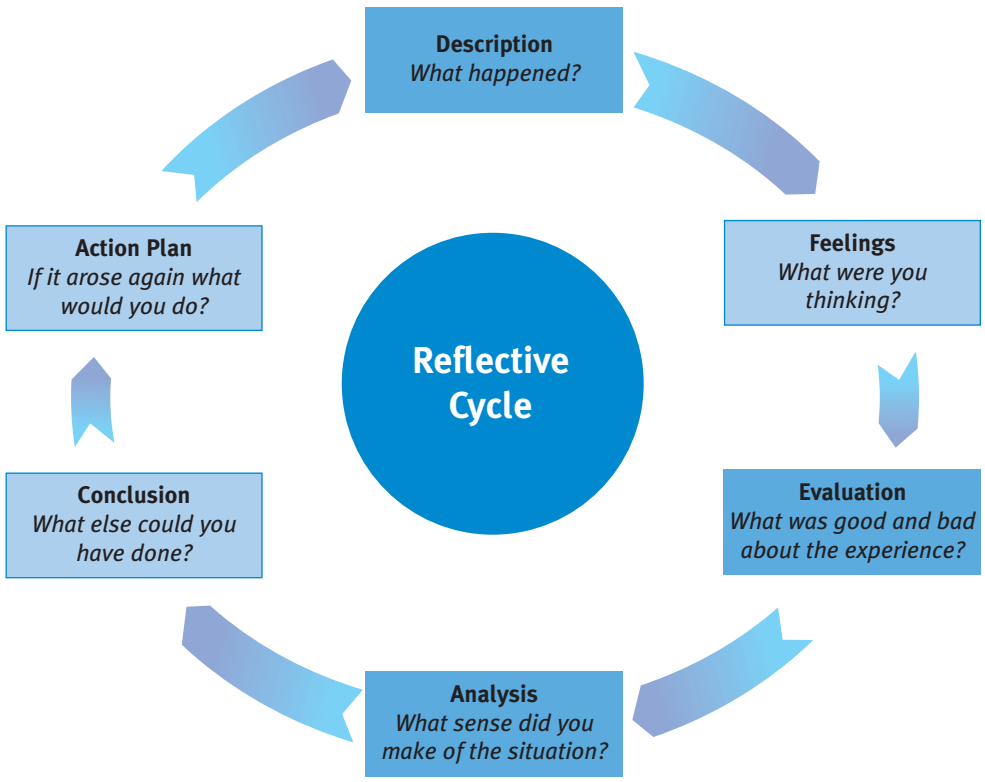
Highlight academic achievements to date. Include copies of certificates and educational awards received. You may find it useful to have a list of when certain competencies were last updated and when they will need to be updated again, e.g., Basic Life Support.

Assessments of your Practice/Reflective Practice Exercises

Assess your practice with reference to evidence-based standards; you may like to use a reflective journal here, or use the critical incident analysis technique which can help you to assess your practice and identify areas for development. A critical incident is something that can be recalled from your professional life, which causes some concern or pleasure. Reflection on the incident allows you to work through the incident, identify influencing factors and explore alternative actions (if appropriate), thus providing insight and understanding for future reference. There are many models for critical incident analysis and reflection in the nursing literature. Gibbs' Reflective Cycle (1988; cited in Johns 2000) is shown below in a simplified format (Box 3.5).

BOX 3.5. GIBBS' REFLECTIVE CYCLE

Source: Johns C. (2000) *Becoming a Reflective Practitioner: A Reflective and Holistic Approach to Clinical Nursing, Practice Development and Clinical Supervision.* Blackwell Science, Oxford.



Documented Feedback

Collect feedback, which may include items such as letters or cards from clients, colleagues or others, references and copies of performance appraisals.

Learning Plans

You can use your personal professional development plan here.

Evaluation of Impact of Learning on your Practice

Reflect on and document how you have used your learning to date in practice. Some of this may become evident through reflective practice.

Additional Information

This section is for your own use, and could include your health or immunisation records.

Checklist for Portfolio

- Is it well organised, well laid out, clearly indexed and labelled?
- Are the contents clear, logical and comprehensive?
- Is evidence cross-referenced where possible?
- Has the portfolio maintained relevance and been kept up to date?

For further reading suggestions refer to the references and bibliography in the National Council's *Guidelines for Portfolio Development for Nurses and Midwives* (2006a).

CHAPTER 4

The Clinical Nurse/Midwife Specialist and Audit and Research

"Audit of current nursing/midwifery practice and evaluation of improvement in the quality of patient/client care are essential requirements of the CNS/CMS role."

(National Council 2007a, p7)

4.1 INTRODUCTION

Chapter 4 will:

- Discuss the CNS/CMS role in relation to audit
- Explain the audit process and discuss the skills required
- Provide guidance and examples in relation to role audit
- Discuss research as an aspect of your role.

This chapter aims to provide you with the foundation knowledge and skills to assist you in fulfilling your responsibilities in relation to audit and research. The approach and processes described can also be applied to any clinical or role audit you may be involved in. Suggested resources for learning more about clinical audit include:

- *Clinical Audit* - the e-learning module on this topic available from www.hseland.ie
- *Best Practice in Clinical Audit* (National Institute of Clinical Excellence (NICE) et al 2002), available to download from www.nice.org.uk
- *Practical Handbook for Clinical Audit* (NHS Clinical Governance Support Team 2005), available to download from www.cgsupport.nhs.uk
- *Healthcare Audit Criteria* (HSE Quality and Risk 2008), available on the HSE intranet only.

(Please note that the authors of the *Clinical Nurse/Midwife Specialist Role Resource Pack* cannot guarantee the accuracy, currency or completeness of the information contained on the suggested websites.)

Research skills appropriate to the CNS/CMS role are referred to in this chapter. However, it must be acknowledged that the resource pack only touches on research. To gain the skills necessary for critiquing and appraising research literature, appraising evidence or clinical guidelines for practice, implementing research in practice and carrying out nursing/midwifery research is outside the remit of this resource pack. We suggest you source evidence-based practice (EBP) study days for these skills and we have made further reading suggestions later in this chapter. Also Appendix 8 provides you with some useful internet websites to start you off.

Chapter 4 is subdivided into the following sections. The first three sections look at audit in general. The other sections are more specific to role audit but we hope they are broad enough for you to identify how you might apply the processes to any audit.

4.2 Why carry out audit?

4.3 What is audit?

4.4 Setting standard statements using the Donabedian Framework

4.5 Approaches to data collection and analysis

4.6 Outcome measures for CNS/CMS audit

4.7 The CNS/CMS and research

4.8 Summary.

Again, as with any new process, if you are a novice practitioner in relation to audit, it is recommended that you read further material and link up with a colleague or a mentor familiar with audit to guide you through your first audits. Chapters 2 and 3 provided you with some tools that assisted you in planning and developing your role, increasing your ability to articulate your role and to recognise where your contributions to patient/client care and your organisation matter most. Audit of your real world practice will assist you to clearly demonstrate the effectiveness of your role's unique and important contribution to patient/client care, nursing/midwifery, and your healthcare organisation. Audit your practice and role from the perspectives of your consumers (e.g., patients/clients, colleagues and peers), nursing/midwifery staff and other healthcare professionals. To ensure that your audit outcomes reflect best practice, you can develop your audit tools and compare your results with available evidence-based information regarding your area of practice. This involves keeping up to date, being well read and capable of interpreting quality and research information. You can save yourself a lot of time and avoid re-inventing the wheel by consulting colleagues and other organisations that have done a lot of work on the area you are interested in.

4.2 WHY CARRY OUT AUDIT?

Initiating, participating and evaluating audit is ultimately aimed at improving patient/client care. Put simply, we audit in order to think about **what** we are doing, **why** we are doing it and **how** we could do it better (Kitson 1990). The report *Building a Culture of Patient Safety. Report of the Commission on Patient Safety and Quality Assurance* states that clinical audit "needs to be at the heart of clinical practice, and is something that all health practitioners should be engaged in. [... Furthermore, it] constitutes the single most important method which any healthcare organisation can use to understand and ensure the quality of the service that it provides" (DoHC 2008, p151). The National Council (2007a) clearly states that "audit of current nursing/midwifery practice and evaluation of improvement in the quality of patient/client care are essential requirements of the CNS/CMS role" (p7). In relation to research, the National Council also states that "the CNS/CMS must keep up to date with relevant research to ensure evidence-based practice and research utilisation. The CNS/CMS must contribute to nursing/midwifery research which is relevant to his/her particular area of practice" (National Council 2007a, p7).

An Evaluation of the Effectiveness of the Role of the Clinical Nurse/Midwife Specialist (National Council 2004b) found that directors of nursing and midwifery thought that audit and research was the least developed core concept. CNSs'/CMSs' reported perceptions of the role also ranked audit and research as the least important of the five core concepts yet on average they reported spending five hours a month on auditing or evaluating the quality of their patient/client care or their own practice. Outcomes that the CNSs/CMSs reported measuring included: numbers seen (81%), effectiveness of interventions (55%); referrals received (54%), referrals made (50%) telephone consultations, waiting times and patient/client satisfaction (approx 40% each). The lack of resources such as time, education in audit and research, and computer packages were identified as barriers to initiating and undertaking audits.

While clinical audit is being advanced in a number of organisations in Ireland, it is not generally linked to service improvements, planning or resource allocation (DoHC 2008). Nevertheless, staff have a duty to themselves and their patients to review their practices, to assure them that what we do is to the highest standard. The Health Service Executive (HSE) also state that "clinicians have a duty to use the findings of audit to improve clinical care and move towards best practice i.e. audit" (HSE Quality and Risk 2008, p3). Other drivers of audit are health policy such as the national Health Strategy (DoHC 2001) and subsequent health strategy and policy documents such as *Building a Culture of Patient Safety* (DoHC 2008); HSE Corporate Plans and quality and risk documents which focus on integrating quality and risk systems for the HSE; the Health Information and Quality Authority's standards and reports, and finally other reviews and inquiries, many of which gain media attention, e.g., the Lourdes Hospital Inquiry (DoHC 2006).

Audit is one aspect of continuous quality improvement (HSE Quality and Risk 2008). Other aspects include clinical effectiveness, benchmarking, care pathways, change management, clinical risk management and accreditation. Though many barriers to implementing audit in your role may exist (e.g., lack of time, resources, knowledge and skills or organisational and peer support), it is nevertheless an expectation of your role (National Council 2007a) and indeed all professional healthcare roles. There are expectations from patient/clients, national policy makers and local organisation/service relating to performance management, demonstrating effectiveness and value for money. (Performance management is the process used by leading organisations to translate strategic plans into action. It involves goal setting and monitoring performance throughout the year (HSE 2008).)

Don't lose heart! The undertaking of audit is often described as a positive, rewarding and interesting process rather than threatening or disheartening. While recognising that audits can be time-consuming and require support and resources to be effective, audits can be beneficial to the CNS/CMS role in bringing about improvements in care. Audit can also raise the profile of your service. The CNS/CMS needs audit in order to "thrive and survive" (Hamric 1989) because the role is still in its infancy and the performance management culture of today's health services requires clinicians to demonstrate their effectiveness. The CNS/CMS who knows his/her own role and specialist area is best placed to carry out role audit (Hamric 1989).

The benefits of audit (Box 4.1) include securing resources for your role and patient/clients, especially when the standards developed are part of an accreditation scheme or benchmarking process where best practice is identified and shared with others. This is particularly true when poor results occur from your audit, showing up flaws in the system. This prompts others to re-look at the situation, prioritise actions and provide resources to remedy the situation.

BOX 4.1. BENEFITS OF AUDIT

- Management and consumers obtain evidence and value of effectiveness
- Management and consumers obtain documentary evidence of compliance with statutory and evidence-based standards
- Results can be used to benchmark with others
- Results can ensure consistency of resources and standards
- Results can provide an action plan to maintain or/and enhance service

Audit gives a voice to your consumers. The consumer's voice is considered very important in any quality initiative and receives particular attention in the current Health Strategy (DoHC 2001) and subsequent healthcare policy. In the audit aspect of your role, your evaluations will give a voice to those who are affected by your work, i.e. your patients/clients, your nursing/midwifery colleagues and other healthcare professionals as appropriate. Role audit/evaluation methodology borrows from the same processes of clinical audit and share the same outcome of improving patient care and current practice.

4.3 WHAT IS AUDIT?

> *A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change* (NICE et al 2002, p1).

Audit comes from the Latin word *audire* (which means "to listen") and has come to signify a systematic examination of practice. Effective audit is based on agreed criteria for good practice, methods for measuring performance/current practice with reference to evidence-based criteria or standards and mechanisms for implementing change in practice (Shaw 1990). If the practice under review is purely medical practice, the audit may be referred to as a medical audit; if the practice is nursing, it is called a nursing audit. Clinical audit involves evaluating the multidisciplinary team's whole practice and its effect on the quality of patient/client care. Batstone

and Edwards (1994; cited in Morrell 1996, p38) define clinical audit as "multiprofessional, patient-focused audit leading to cost-effective, high-quality care delivery in clinical teams". Clinical audit systematically reviews every-day care and is probably the most widely used audit in health. Fundamental to the process of audit are the concepts of "comparison, feedback and repetition" (NICE et al 2002). NICE et al (2002) are regarded as having produced the definitive definition and evidence on clinical audit. *Best Practice in Clinical Audit* (NICE et al 2002) is available on line at www.nice.org.uk.

When implementing audit in practice, the process generally follows a cyclical method known as the audit cycle (Figure 4.1) or indeed, as this is often an ongoing process that is repeated - the audit spiral. The cycle involves identifying best practice, defining the expected level of quality, measuring and comparing actual practice against the expected level and taking action to improve any deficiencies that are identified or to celebrate where you are doing well. The Spiral suggests that the process is continuous; each cycle aspires to a higher level of quality (NICE et al 2002, p3).

FIGURE 4.1: THE AUDIT CYCLE (Adapted from NHS Executive 1998)

Change is a central tenet of the audit process. It must be remembered that the primary purpose of audit is to identify opportunities for improvement of patient/client care and to identify ways to bring this improvement about, e.g., auditing the CNS/CMS role to identify your current impact on patient/client care and how this can be improved. Secondary outcomes of audit include providing data for practice and making optimum use of resources, thereby improving service organisation and service planning. Audit topics or issues you feel would improve patient/client care should be addressed as audit has been shown to promote positive change if there is a commitment to the audit process and the audit cycle (Figure 4.1) is complete. Johnston et al (2000) attempt to define a successful audit from the healthcare professional's viewpoint and suggest success should be measured by quantifying the extent to which your audit matched the audit cycle.

While audit may use research methods (e.g., questionnaires, interview techniques, etc) as part of the measurement phase of the cycle, audit itself is not research. Audit is designed to measure the effectiveness of care under "real world" conditions. Furthermore, audit is the evaluation of the application of research findings in practice rather than actual research (Malby 1995). Malby outlines the differences between audit and research in Box 4.2 below.

BOX 4.2: DIFFERENCES BETWEEN AUDIT AND RESEARCH (Malby 1995, p29).

AUDIT

- Promotes evidence-based decision-making
- Is not randomised
- Compares actual performance against pre-tested standards
- Is conducted by those providing the service
- Does not involve instigation of new treatments but evaluates current treatments
- Involves review of records by those entitled to see them
- Does not necessarily have to be endorsed by the ethics committee, unless patients are to be personally involved (e.g., through interviews)
- Does not produce results transferable to other settings
- Uses tested hypotheses to develop standard
- Compares performance against standard

RESEARCH

- Is randomised
- Identifies the best approach, and thus sets the standards
- Is not necessarily conducted by those providing service
- Usually initiated by researchers
- Involves comparisons of new treatments and placebos
- Requires access by those not normally entitled to access
- Must be endorsed by ethics committee
- Produces results that may be generalisable to other settings
- Determines a testable hypothesis grounded in empirical data
- Presents clear conclusions

4.4 SETTING STANDARDS USING THE DONABEDIAN FRAMEWORK

Grimshaw and Russell (1993; cited in NHS Executive 1998) defined standards of care as "authoritative statements of (a) minimal levels of acceptable performance or results, or (b) excellent levels of performance or results or c) the range of acceptable performance or results" (Part 5, p4). This implies that the standard statement you write is often an individual target level of performance, depending on your chosen topic and what is known about best practice in that area. The standard will also depend on the situation/environment you work in and what is considered appropriate levels of attainment for your audit topic in your particular environment. It is important to ensure your statement is "authoritative" by ascertaining it is authentic and valid; that it is evidence-based, and promotes best practice. Once you have chosen your audit topic, identifying best practice, agreeing and documenting your standard statement are the first steps in your audit cycle.

Identifying Best Practice

Commonly used sources of best practice information are peer-reviewed, evidence-informed best practice websites and on-line databases of journals. In reviewing the nursing, midwifery and health literature you may identify best

practice standards and even audit tools that you could adapt or apply to your audit. In selecting a standard, you must appraise it for relevance to your practice area and level of evidence informing the standard development. Appendix 8 provides useful websites to make your search easier. You can enhance the validity and credibility of your audit by having an evidence-based audit tool and standard/expected level of performance for your audit.

Clinical practice benchmarking has been defined as "a process through which best practice is identified and continuous improvement pursued through comparison and sharing" (*Making a Difference,* DoH 1999, p49). Two UK clinical benchmarking resources are the *Essence of Care* benchmarking framework (DoH/NHS Modernisation Agency 2003) around the activities of daily living and Beacon sites (www.nhsbeacons.org.uk). The *Essence of Care* benchmarking framework is available to view or download from the internet at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/. The benchmarks were developed in consultation with the public and patients and represent their views on quality.

Other sources of best practice are peer-reviewed performance indicators (PIs) often included in government publications (e.g., health strategies and commission reports). National working groups and the Department of Health and Children have developed many PIs for eleven care groups in the Irish health services. The eleven areas are Health Promotion, Overall Health, Primary Care, Acute Services, Mental Health Services, Child and Adolescent Health Services, Child Care, Older Persons, Disability Services and Social Inclusion. (You may need to compare these to groups identified in HSE service and corporate plans.) If you search these and other literature in relation to your discipline of nursing/midwifery, you may identify appropriate PIs against which you can compare your actual practice.

Documenting Best Practice

It is important that you can write achievable, authoritative standard statements that are based on current evidence and policy. Standard statements generally involve agreement on the overall objective and expected level of practice towards which you and others work. In general, you cannot write standards on your own as many of your standard statements will affect others (Girvin 1995). The Dynamic Standard Setting System (DySSy) developed by Royal College of Nursing (RCN 1990) has been widely used in nursing audit and provides a useful framework to write your standard statements. This framework is based on Donabedian's (1980) approach to standards and evaluating quality in healthcare. The identification of how and what to do, to make your standard achievable and measurable are detailed as "criteria". Criteria are further explicit statements that define and expand on what is being measured in the overall broad standard statement. Criteria are sometimes used on their own in audit with an associated target level of performance and this method of audit is called a "criterion-based" audit as distinct from the full standard statement Donabedian (1980) or DySSy (RCN 1990) framework. For the purpose of the role resource pack and because the Donabedian/DySSy framework often suits when setting up and auditing a new service, this framework will be explained in the pack. The criteria aspect is included within this framework.

Applying the Donabedian Framework to Your Standard

Donabedian's Structure-Process-Outcome framework/approach (cited in Malby 1995, p53) defines the various components assessed by audit and breaks down your standard statement into measurable criteria as follows:

1. ***Structure criteria*** - these relate to all elements creating the environment of care/setting in which care occurs. This includes material resources, human resources and organisational structure, including the number and competence of the staff. Often, it is important that specialists make accurate and valid data available so that it can be utilised in decisions about the allocation and utilisation of resources within their speciality. Structure criteria in relation to role audit involves identifying the resources available to the CNS/CMS to carry out his/her role in line with the National Council's definition and the five core concepts (2007a).
2. ***Process criteria*** - relates to all elements involved in the delivery of care/what activities are actually involved in how we provide care, in the giving and receiving of care including diagnosis, treatment and procedures. This takes account of methods of organising nursing staff and nursing care. Regarding role audit, process includes how/what activities the CNS/CMS can utilise to apply the five core concepts to his/her role.
3. ***Outcome criteria*** - relates to all elements demonstrating results of care; refers to the effects of care on the health

status of the patients and populations. This includes patient satisfaction with treatment or the degree of improvement in the patient's health as a result of care received. A change in a patient's current and future health status that can be attributed to antecedent health care (Donabedian 1980). Outcome in relation to audit of the CNS/CMS role would look at all elements that can demonstrate the application of the five core concepts to the CNS/CMS role. Performance outcome measurements are discussed in the CNS/CMS role evaluation report (National Council 2004b, pp26-28 & 36-37).

It is useful to consider audit under the above criteria headings but at times distinctions between structure, process and outcome may become unclear. There is a school of thought that to confidently relate patient outcomes to a nursing intervention requires qualitative research since measuring quantifiable outcomes alone is inadequate (Hamric 1989; French 1995). The problem arises because care is a continuum where the patient/client will meet a range of healthcare professionals. Studies indicate that nurse-led interventions are as effective as medical care (Garvican et al 1998; Mackintosh & Bowles 1997; Hill 1994) but more rigorous studies from nursing are commonly requested. Another reported difficulty with the Donabedian framework is that it can be unclear what criteria fall under resources (structure), ways of doing (processes) and end deliverables (outcomes). Box 4.3 includes a checklist for your standard statement to help you develop a robust statement and associated criteria. Ultimately, your evidence-based standard statements must depict the expected standard of practice and are criterion-based to establish links between structure, process and outcomes (Girvin 1995). Your overall standard and criteria must be measurable and relate to important aspects of care.

BOX 4.3: FEATURES OF A STANDARD STATEMENT

Is your standard statement SMARTER

Specific - who/what/when/where/how
Measurable - clear measurable outcomes
Achievable - identify the minimum, ideal and realistic standard
Relevant - to your organisation/service/role
Time-bound - timeframe included
Effective - based on best practice
Researched - based on up-to-date evidence

Does your statement meet the RUMBA test? (Royal College of Nursing 1990)

Reliable
Understandable
Measurable
Behavioural
Acceptable

Standards have been used in both clinical and nursing audit but it is possible to use standards for specialist nursing roles (Hartley & Cowe 1997; Hamric 1989). The following section takes you through a standard statement for the Mary, the CNS (Asthma) in our case study. (Other case studies are available on the CD-ROM accompanying this pack.) The standard statement is broken down under the structure, process and outcome criteria (the Donabedian model) and has been adapted from the *Role Evaluation Resource Pack* (Hartley & Cowe 1997). You can adopt this framework for any standard statement. If you are not familiar with writing standards, seek help from others with experience, for example, a member of your nursing/midwifery practice development unit or a member of staff at the NMPDU in your region.

CASE STUDY: MARY - CNS (ASTHMA) *A STANDARD STATEMENT APPLIED TO ROLE AUDIT*

Topic: Role of the CNS in Asthma

Sub-topic: Clinical focus (indirect care) Education and Training (of staff)

Care Group: In-patient requiring treatment for asthma

Achieve by (date): | **Review by** (date):

Standard Statement: The CNS will provide in-service education sessions for ward staff on topics relating to the management of asthma and new developments in asthma. This will occur on a monthly basis to improve the staff's level of knowledge and the management of patients at ward level.

Background/rationale: Mary (CNS - Asthma) has noted increasing number of bleeps from ward regarding relatively "simple" queries. She believes this is due to a relatively high staff turnover and suspension of the in-service education programme on asthma. A baseline evaluation of the educational needs of staff showed moderate knowledge levels in key areas of asthma management and a high level of interest in re-commencing in-service education programme for staff.

(**Evidence:** Up-skilling staff will improve quality of patient care (Benner 1984; Hamric & Spross 1989; Castledine & McGee 1998; Marshall & Luffingham 1998).

The above standard statement is then broken down into individual criteria.

STRUCTURE	PROCESS	OUTCOME
CNS, ward management structure and adequate staffing	Staff and ward managers are aware of education sessions and topics two weeks prior to sessions	Education sessions are attended
Education room located close to wards	Sessions are held on a monthly basis	Management of patients at ward level improves from baseline audit Patient survey results show high levels of satisfaction Number of charts reviewed increases Number of bleeps/calls to CNS about simple queries decreases
Protected time allocated for staff education	Staff are released to attend sessions	Staff level of knowledge improved Improved test results among staff
Publicity and educational materials on specific topics made available	CNS preparation, facilitation and evaluation of education sessions to include booking education room, preparing hand-outs, developing distribution and analysing evaluation sheets, adapting sessions in response to feedback	Survey shows increased staff satisfaction with education sessions
Audit forms to include level of patient satisfaction with their overall management during hospital stay	Audit of patient charts designed to assess quality of asthma care by ward staff	
CNS and staff given protected time to audit chart and patient satisfaction survey	Audits carried out by CNS with member of ward staff prior to session and every 6 months thereafter	
CNS allocated time and tools to evaluate staff knowledge level and satisfaction with education sessions	Patient satisfaction survey carried out prior to session and every 6 months thereafter	

At this stage, the criteria in the standard statement that you must measure are identified to develop audit indicators. Your particular topic or priority will determine which aspects you focus on. You may be inclined to measure outcomes only, believing if your outcome results are good then everything else must be working well. However, outcome measurement on its own does not tell you if the achieved outcome actually relates to what you did or did not do (process). Hamric (1989) recommends that the CNS evaluates both process and outcome but the decision must be informed by the topic. Girvin (1995) recommends you "measure all criteria, at least at the beginning" (p41).

CASE STUDY: MARY - CNS (ASTHMA) ***EXAMPLE OF AUDIT INDICATOR/CRITERIA/AREA FOR MEASUREMENT***

STATEMENT	STANDARD	EXCEPTIONS	EXCEPTIONS
The CNS will provide in-service education sessions for ward staff on topics relating to the management of asthma and new developments in asthma. This will occur on a monthly basis to improve the level of staff knowledge and the management of patients at ward level	100%	Staff who have not been on the ward for longer than one month	**In-service** = sessions inside organisation
			Ward Staff = nursing staff on wards where asthmatic patients cared for
		Patients who spent less than 24 hours as an in-patient	**On a monthly basis** = same day each month, one 40-minute session every month
			New development in asthma = new literature on medications, other treatments or nursing
			Patients at ward level = in-patients with asthma
			Improve management of = care pathway reflects best practice and high patient satisfaction

The definition of the audit indicators in the far right-hand column tells you precisely what is meant by each term and points out the areas for measurement. There are two main ways to monitor your criteria: by observation or by asking questions (Girvin 1995). Observing includes chart/document reviews, environmental checks and observing practice. Asking questions involves "asking nurses, patients, carers, other professionals, anyone relevant, either by questionnaire or by some kind of interview" (Girvin 1995, p 31).

Having decided what and how you will monitor your criteria, you must decide on how many respondents require surveying or observation. Remember this is audit and not research. Therefore, the sample size does not have to be large. This is particularly true when looking at the processes of care and measuring them to provide an indication of the quality of care. When looking at outcomes of care, specifically those which have a numeric response, the use of random sampling and a sample size calculator is recommended. Visit www.ubht.nhs.uk/clinicalaudit to read more on this. Taking into account the resources and time available to you, it is important that your sample is of adequate size to reflect and represent the common characteristics of your audit topic or patient/client group.

Remember, the standards you set for the different aspects of your role or your practice should be evidence-based, i.e., shaped by the empirical knowledge and research that exists concerning your audit topic and reflecting effective appropriate practice. Having searched the literature on your topic, you may see a gap in care that you would like to rectify or a new intervention that you might implement in practice for six months prior to conducting your audit. For example, in the above audit, staff may require best practice protocols or guidelines in asthma management to be disseminated and implemented prior to audit. You may find literature supporting the use of link nurses in your specialist area achieving higher results in your desired outcomes compared to in-service education sessions. Consider all changes in relation to your work environment and the resources available to you. The library services offer assistance in carrying out detailed searches and you may find relevant study days in your regional education and training prospectus. Some useful websites are included in Appendix 8. For HSE employees the website www.hselibrary.ie will provide you with a list of journals and on-line databases available to you locally.

CASE STUDY: MARY - CNS (ASTHMA) *EXAMPLE OF AUDIT TOOL*

- Quantify number of in-service sessions held
- Record and collate number and profile of attendees
- Analyse evaluations, looking at timing, venue location and topics covered in education sessions, level of attendee satisfaction and any ideas for improvement
- Make changes to education sessions as per identified needs
- Over a six-month period, randomly select "30" sets of asthmatic patient notes from relevant wards (the number of charts reviewed should reflect a minimum of 20% of patients admitted)
- Check nursing notes for evidence of care plan for asthmatic patient
- Check notes for deviation from the "norm" in relation to best practice
- Identify percentage admitted, percentage who deviated from expected course of recovery; identify those who had documented evidence of nursing care on problems related to asthma; identify those where inappropriate decisions about care were made

Your criteria detailed what you want to measure and you may have decided how you will measure your criteria, i.e., through observation or asking questions. Often, due to resources, asking questions using a questionnaire is the chosen method. The next sections look at factors to consider when collecting data for your audit and then look at questionnaires in more detail. Some of this is sourced from research methodologies. If you are new to the terminology you may need to do some further reading.

4.5 APPROACHES TO DATA COLLECTION AND ANALYSIS

In deciding what information to collect it is helpful to specify what outcomes measures you are hoping to demonstrate in your final report or evaluation. Focusing on these outcomes measures will guide you in terms of the kind of data you need to collect and how to go about analysing that data. Here we will take time out to look at the two main types and approaches to data - quantitative and qualitative - so you can decide what approach to take to demonstrate your outcomes measures/indicators in your audit.

Quantitative Data and Approach

When collecting quantitative data you are mainly looking at numerical information ranging from actual numbers (e.g., number of participants in audit, number who agreed or disagreed with question X) to numbers representing another value (e.g., Borg scale 0-10 to measure pain or a Likert scale to measure respondents' satisfaction with a given situation) or a visual analogue scale (see the example below). Quantitative data is useful for measuring how much, many or often an activity or behaviour occurs. It is useful for breaking down complex phenomena or facts to simple units (reductionism) and usually involves measurement but is also used to describe, assess and evaluate the extent or degree certain phenomena occur (Parahoo 1997). This quantitative data will make analysis and reporting on the incidence or descriptions of your findings easier.

EXAMPLE OF A QUESTION COLLECTING QUANTITATIVE DATA (Hartley and Cowe 1997)

- **How valuable was the support during patient discharge provided by the CNS (Asthma)?**

(Please circle your answer)
1=of no value
5=invaluable

Or you could use simple "closed" questions, i.e., questions requiring a **yes** or ***no*** response

- **Did you find the support offered by the CNS (Asthma) helpful during your discharge from the clinic?**

Please tick *YES* ☐ *NO* ☐

Count up "yes's" and "no's" to get an overview of responses, e.g., "18 out of 20 respondents said the specialist nurse helped with question asked".

Qualitative Data and Approach

If using a questionnaire to collect qualitative data, you gather mainly narrative descriptions in response to open-ended questions or requests for comments; for example, asking for an explanation for replying in a particular way to a previous question or acting in a certain way. Qualitative analysis attempts to "make sense" of a process, giving meaning and significance to actions or beliefs (Parahoo 1997). Parahoo also states that the qualitative approach is more appropriate (i.e., than the quantitative approach) when studying the experiences or perceptions of patients/clients, nurses or others. Qualitative data can also be obtained from the use of diaries, interviews or through observation to elicit more details on a person's actions or beliefs. Box 4.4 outlines the contrasting characteristics of quantitative and qualitative approaches to research.

BOX 4.4: DIFFERENTIATING BETWEEN QUANTITATIVE AND QUALITATIVE DATA (Parahoo 1997)

QUANTITATIVE	Quantitative
• Reductionist +/- deterministic	• Holistic
• Method predetermined / structured standardised and inflexible	• Method semi and unstructured, flexible
• Purpose to measure	• Purpose to describe +/or theorise

Combining Quantitative and Qualitative Approaches

To gain meaningful insight into your patients'/clients', nursing staff's and other colleagues' view of your role, a combined approach utilising both quantitative and qualitative data is often beneficial. This approach can highlight many influential variables in outcome achievement. You can achieve this approach using questionnaires.

Questionnaires

One of the easiest ways to obtain information to demonstrate the purpose of your audit is to survey the appropriate people using a questionnaire. A questionnaire allows you to incorporate a quantitative and qualitative approach, in a user-friendly manner. The following sub-sections look at developing questionnaires for your role audit. You need to involve your stakeholders in your audits, especially in your role audit. The sample questionnaires shown in Appendices 10, 11 and 12, are taken from the Heatherwood and Wexham Park Hospital NHS Trust's *Specialist Role Evaluation Pack* (Hartley & Cowe 1997).

Appendix 9 provides general tips on developing and disseminating a questionnaire but a few points are worth highlighting here. It is wise to brainstorm your audit topic with a small sample of the population you intend to survey. This will provide you with insight into their views and assist you in formulating the actual questionnaire so that it is relevant to the respondents. It may highlight any ethical issues (e.g., appropriateness, permission and consent) you could have overlooked.

Pilot your questionnaires with a small sample to ensure the questions are pitched at the right level and easily understood by respondents. Analyse the pilot data to see if you are able to evaluate your questionnaire as you expected and are obtaining the information you want. At this stage, you may want to make changes to the wording of your questionnaire and add or remove questions.

When sending out your final questionnaires, be objective about the sample you choose, ensuring that respondents are capable of answering the questionnaire, that they reflect your service users and/or audit topic in general but yet, are not hand-chosen by you. This could introduce "bias" into your audit results. Your sample size should be representative of (i.e., reflect) the population affected by your audit topic. To ensure a high response rate to your audit, a questionnaire could be sent to all possible respondents. If you need to control the number of respondents, you could randomly choose every third potential respondent. It is important that your audit sample size is "do-able" within your resource constraints (time, access to data, data analysis and cost) and "representative".

Enclose a cover letter. Mark the day and the return-date clearly on your letter and questionnaire. Reminder letters are often necessary to achieve the desired response rate.

Keep your line manger and relevant clinicians informed of any audits you are carrying out regarding the service; permission may be required if there are any costs involved. Most questionnaires, unless covering very sensitive subjects, do not need ethics committee approval, but it is advisable to check with your manager. Return of data is considered consent to use data as outlined in your cover letter. If you have patient information leaflets for your service it is advisable to add that audit is part of your role and periodic review of patient charts, or the use of questionnaires and interviews will be used for this purpose, allowing patients to opt out if they so wish.

Presenting Your Findings

Chapter 5 *(The Clinical Nurse/Midwife Specialist and Report Writing)* discusses the report-writing templates which will be appropriate to your audit report. Having analysed your data, whether with the assistance of a computer package, Excel or by hand, graphs and tables will be required to help you feedback your results to those relevant stakeholders. However, graphs can be misleading in some cases. Dangers include choosing the incorrect type of data to be displayed. Comparison between parts of the whole can be displayed in bar graphs or pie charts (e.g., profile of those who attended study days). Some bar charts and line charts are appropriate at showing change over time. Before designing your graph there are some questions you can ask yourself to help you choose the most appropriate format (Box 4.5).

BOX 4.5: CHECKLIST FOR GRAPHS

- Is the data clearly presented in the graph chosen?
- Does it encourage the viewer to think about the data?
- Are there features that could cause misinterpretation?
- Is the graph appropriate to the audience/reader?
- Does it make more sense of the data than any other option, e.g., tables?

Patient/Client Questionnaires

> *"The difference between the provider of health services and the patient resembles that between the hen and the pig in the preparation of eggs and bacon. The hen is involved but the pig is committed."* Anderson (1989; cited in Parsley & Corrigan 1999, p138)

As previously noted, audit gives the consumer a voice. Involving the patient/client in your questionnaire is necessary to understand their expectations regarding your role, their views on the quality of your care and to know what you are doing well and what areas you could improve on. Methods of eliciting information from patients include focus groups, interviews, questionnaires, comment cards and incident reporting. Questionnaires are generally accessible to most people and there is a lot of literature available regarding patient satisfaction surveys to assist you in this process. Do consider having a small focus group or brainstorming session before formulating your questionnaire as this will help you identify the key issues, formulate appropriate questions and ensure service users feel involved in the process. Keep your questionnaire relatively short and easy to understand so all patient/clients can answer the questions.

It is usually best to keep such questionnaires to no more than two sides of A4 paper, to maximise your response rate (Hartley & Cowe 1997). Give the opportunity for an open-ended question at the end of the questionnaire for the patient/client to expand on any aspect of the service that is concerning them. You may have already checked informally with patients/clients if they are happy with the care they are receiving but you need to formally evaluate if you want documented evidence of effectiveness. The audit will elicit more impartial results if administered after discharge home from the service and/or if you can organise that returns are sent to an appropriate third party (e.g., departmental secretary, audit department or other relevant department). This allows the patient/client to feel less

inhibited in their responses. The easiest way to distribute your questionnaire to patients is to give one to each patient after an episode of care, with a stamped addressed envelope for their reply. Alternatively you could conduct a postal survey using patients' details from your records. The sample questionnaire in Appendix 10 can be adapted to reflect your specialist area and individual needs.

Nursing Staff and Clinicians Questionnaires

Most CNSs/CMSs will have close and often dependent working relationships with other nursing staff and with other clinicians. To carry out a full 360º review of your role, their views on the quality of your service must also be evaluated (Humphris 1999). This may seem rather threatening but it is vital that the services offered by specialist nurses are also responsive to the needs of nursing colleagues and the whole health care team. The National Council's (2007a) five core concepts discuss your indirect clinical focus (i.e., activities that influence others in the provision of care) and your sub-roles as consultant and educator of other staff. How will you know if you are effective in these, if you do not ask the relevant people the relevant questions? Sample questionnaires for use with nursing and medical staff are provided in Appendices 11 and 12. The questionnaires can be amended to reflect your specific area or audit topic. It is important that those surveyed are appropriate, i.e., people who know your work, but also that they are impartially selected, i.e., not specifically chosen by you as this could introduce bias. The questionnaires are best kept short and simple to increase the response rate from busy staff. They can be sent out via the internal post and returned to an appropriate, private collection point.

4.6 OUTCOME MEASURES FOR CLINICAL NURSE/MIDWIFE SPECIALIST AUDITS

Many of the questionnaires discussed so far relate to evaluating the structure and process of your role. Measuring the outcomes and impact of your care is also important. It can be difficult to identify your specific “outcomes”, particularly if much of your work is team-based. This is where clinical/multidisciplinary audit often plays a role in measuring the effectiveness of the team. However, it is still possible to identify some of the effects of your interventions, and to highlight where you “made a difference”.

Firstly, you need to decide what key outcomes you would expect from your care. Obviously in the current “performance management” health care climate, any outcome measures that may show cost savings such as less drug wastage, or fewer admissions are particularly useful. However, cost-containment should not be seen as the only important aspect of outcome measures. Others are improvement in the quality of care and the quality of life for your clients/patients. Hamric (1989) has written in depth about evaluating the American CNS role. Her application of the Donabedian framework to the CNS role is worthy of further attention (Appendix 13). Hamric looks at the CNS' impact on patient outcomes under the following sub-headings:

Physical parameters - health status, presence or progression of disability; alleviation of symptoms are measured; length of stay; number of hospital re-admissions

Cognitive - increased patient knowledge

Psychosocial - improved social interaction or family understanding and/or participation. Behavioural outcome - patient's adherence to a therapeutic regime.

While it is useful to review outcomes in the international nursing and midwifery literature, it should be remembered that terminology, structures and processes may not be comparable to those used in Ireland. It should also be acknowledged that the CNS in the USA is more comparable to the Irish advanced nurse practitioner (ANP) so some of the outcomes may not be achievable in an Irish setting. Interestingly, one British study (Roberts-Davis & Read 2001) that found that there were more similarities between nurse practitioners and clinical nurse specialists than there were differences, but the absence of a framework for the clinical career pathway in the UK makes such a comparison difficult to endorse. Also Hamric acknowledges that there are problems with evaluation of such outcome as it is often a very large task with other variables influencing the outcomes. Distinguishing such variables may require nursing research. Appendix 13 illustrates the evaluation of the CNS role using Hamric's model.

The following ideas for outcome measures for the CNS (Asthma) in our case study have been adapted from the *Specialist Nurse Role Evaluation Pack* (Hartley & Cowe 1997). (Other case studies are available on the CD-ROM accompanying this pack.) I have highlighted which core concept the CNS actions relate to in each box, but as all involve audit, they all relate to the core concept - audit and research.

CASE STUDY: MARY - CNS (ASTHMA) *IDEAS FOR OUTCOME MEASURES* (Adapted from Hartley & Cowe 1997)

IDEAS FOR OUTCOME MEASURES (1)

Core Concepts: Clinical Focus (Direct Care) and Education and Training (of the Patient)

Imagine Mary and her work as an asthma specialist nurse. She could consider evaluating her impact on patients' understanding of their drug therapies.

1. Firstly, she could formulate a short questionnaire to assess the patient's baseline knowledge levels.
2. Then after an agreed programme of education, based on best practice in patient education and complemented by a learning pack she had put together, she could repeat the questionnaire. It may be possible to detect an improvement in patients' knowledge and understanding of their therapies. The next step is to identify whether this improved understanding has translated into better management of their condition.
3. She could examine the number of acute admissions to hospital amongst those patients who have received her learning pack.
4. She could then compare this to the average re-admission rate amongst her patients prior to this exercise. Alternatively she could track the re-admission rate of individual patients before and after the pack, and see whether any reduction in frequency could be detected. If re-admission rates were not showing any differences, perhaps length of hospital stay has changed in those who received the learning pack.

IDEAS FOR OUTCOME MEASURES (2)

Core Concepts: Clinical Focus (Direct & Indirect care) and Education & Training (of Patient)

Perhaps interventions by the CNS (Asthma) could help clients stop smoking

1. First identify smokers within client caseload (the sample)
2. Provide advice about benefits of smoking cessation and publicise availability of smoking cessation service to all smokers. Assess smokers to identify those interested in stopping, using an evidence based approach, e.g., using the wheel of change.
3. Provide a course of counselling/brief interventions for the sample focused on stopping smoking, giving advice and support on the availability and use of nicotine replacement therapies.
4. Offer the sample a telephone number where they can phone to get support if they are experiencing a problem with cessation
5. Six months later measure the numbers still smoking aiming to identify any reduction.

IDEAS FOR OUTCOME MEASURES (3)

Core Concepts: Clinical Focus (Indirect Care), Patient Advocacy and Consultancy

Perhaps better liaison between the hospital and community services by a skilled specialist nurse could *reduce the length of in-patient stays* experienced by these patients during an acute exacerbation of their asthma.

1. Examine records to identify average length of hospital (ALOS) admission amongst patients in the year before CNS (Asthma) was in post and/or liaison activity occurred.
2. Now identify ALOS for the year after CNS (Asthma) came into post (don't count the first 6-8 months as this may be too early for impact to be made).
3. Is there any improvement? It may even be possible to find out the ALOS of asthma patients nationally or in a similar organisation with similar profile to compare results.

Bear in mind that many other factors such as the environment, new drug therapies or services available in the community may affect length of stay; however, you may be able to identify some clear links to your practice or report reduced length of stay as an outcome related to many variables, one of which includes the CNS role.

Use a post-training evaluation sheet to gain insight into how participants viewed your training, areas for improvement and further topics staff may like covered.

Hartley and Cowe (1997) also suggest another possible approach to outcome measurement is to formulate and set personal outcome measures/targets with individual patients, and then monitor how well these have been achieved. This could be collected from audits of your own nursing documentation by evaluating whether a goal has been

IDEAS FOR OUTCOME MEASURES (4)

Core Concepts: Clinical Focus (Indirect Care) and Education and Training (of Staff)

Could in-service training by CNS (Asthma) help nurses to feel more confident when teaching patients inhaler technique?

1. Assess baseline confidence and competence by working with nurses teaching inhaler technique, using a short self-assessment questionnaire.
2. Provide update sessions on inhaler technique for nurses with theory, practical demonstration and participation.
3. Reassess competence and confidence after session through asking them to again complete the quiz, and demonstrate how they would perform the technique against identified criteria.

agreed and documented and whether there is any evidence that it was achieved. This is a very patient-focused approach and provides you with insight into your work patterns and the effectiveness of many of your interventions. Also recommended in the *Specialist Nurse Role Evaluation Pack*, as part of the process of developing awareness of your "impact", do keep a note, brief description and any supporting evidence when there is an occasion where you feel you were responsible for any change in your practice or clinical practice in general or in service improvements. Use the five core concepts as a framework to identify potential outcomes and as a checklist to ensure you have not omitted any important outcomes (Activity 8). (A Word version of this activity is available on the CD-ROM accompanying this pack.) Outcome measurements are discussed in the CNS/CMS role evaluation report (National Council 2004b, pp26-28 & 36-37).

ACTIVITY 8: ROLE AUDIT OUTCOMES USING THE FIVE CORE CONCEPTS

CORE CONCEPT	EXPECTED OUTCOMES	OUTCOMES FOR AUDIT
Clinical Focus Direct and indirect care		
Patient Advocacy Individual and group		
Education & Training Patient, self, other staff		
Audit & Research Audit of current practice and quality of patient care ***and*** research utilisation and contribution to nursing/midwifery research		
Consultancy Intra- and inter-disciplinary; internal and external		

4.7 THE CNS/CMS AND RESEARCH

The role of the CNS/CMS in relation to research is primarily concerned with using and disseminating best practice The National Council's (2007a) definition of the CNS/CMS and five core concepts require that the CNS/CMS participate in and disseminate nursing/midwifery research and keep up to date with relevant current research to ensure evidence-based practice and research utilisation. There is a need for clinical practice to be based on the "best available/best in class" evidence. The use of knowledge and evidence in nursing and midwifery practice is becoming more prominent with increasing amounts of literature for the nurse or midwife to review, evaluate and implement. If the role of the CNS/CMS encompasses improving patient care and developing nursing/midwifery practice, research and research utilisation must also feature in the role. Developing and disseminating locally adapted evidence-based guidelines to promote and govern best practice in your specialist area is a key expectation of the role (National Council 2004b). Therefore, you must be capable of discriminating between knowledge based on opinion and that based on scientific evidence and systematic reviews. Rosenberg and Donald (1995; cited in Parahoo 1997, p94) outline four steps in evidence-based medicine/practice: "Formulate a clear clinical question from a patient's problem; search the literature for relevant clinical articles; evaluate (clinically appraise) the evidence for its validity and usefulness; and implement useful findings in clinical practice".

The CNS/CMS, as a role model, educator and clinical leader in his/her specialist area is seen as a source of knowledge for other nurses/midwives. In a study of 122 nurses in clinical practice in the UK, human sources of information for practice were overwhelmingly perceived as the most useful and clinically credible information source in reducing the clinical uncertainties of nurses' decision-making (Thompson et al 2001). It was not the research knowledge *per se* but the medium (source) through which it was delivered that was most influential. This implies that the CNS/CMS is well placed to act as a role model for developing practice through research utilisation.

It is recognised, however, that some CNSs/CMSs will have the opportunity to conduct research as part of an education programme, replication of previous research conducted or as part of research being conducted by a team in the clinical area. Indeed some CNSs/CMSs have conducted and published primary research. As part of their personal development planning, CNSs/CMSs should consider existing opportunities for more involvement in research. Such opportunities could support them to build their research skills and competencies.

Reasons for not engaging or implementing research findings are well reported in nursing literature (HSE NMPDU South (Cork and Kerry) 2007; DiCenso et al 2005; Thomson 2001; Parahoo 2000; Nilsson Kajermo et al 2000; Ibbotsen 1997; Hunt 1996). The reasons and barriers cited are summarised in Box 4.6.

BOX 4.6: REASONS FOR NOT IMPLEMENTING RESEARCH IN PRACTICE

- Lack of skill in evaluating quality of research
- Isolated from knowledgeable colleagues with whom to discuss research
- Lack confidence to implement change
- Insufficient time to go to library/to read
- Inadequate library services/access to evidence
- No/very few nursing research committees
- Nursing based on tradition
- Lack of interest in research
- Not many/few systematic reviews relevant to nursing
- Research not studying real life problems of practitioners
- Perception that nurses do not need research
- Lack of support from manager/or lead clinicians / not allowed to use/implement research findings
- Do not manage to persuade, convince others of their value
- Lack of organisational support/lack of vision for EBP

The CNS/CMS can participate in research at three different levels.

Level 1: CNS/CMS plays a role in explaining, evaluating and communicating the research findings related to their practice area to other nursing staff. This requires judgement of the findings validity and reliability.

Level 2: CNS/CMS applies the significance and implications of the research findings for patient care. This requires baseline measurement of existing care, introduction and implementation of guidelines, policies and protocols. Evaluation of post-implementation measurements are required.

Level 3: The CNS/CMS conducts research on an individual basis or as part of a team. It should be noted that this has time and cost implications. Kitson (1997) states that the ability to generate knowledge in the first place is related to authority and control over one's own environment, where it is much more likely for systematic observation of practice to be undertaken where the conditions needed to control the intervention and the subjects are within reach of the individual clinician.

Opportunities now exist for CNSs/CMSs to establish a strong/stronger research component to their role across these levels. Improvements in nurse/midwife education and the research strategy for nursing and midwifery in Ireland (DoHC 2003) have provided impetus for this. You will have individual research needs depending on your level of experience in research utilisation or research generation. This resource pack is unable to provide you with all the skills you may require but the following may assist you in identifying ways to meet your individual research needs.

- If you log on to www.ncnm.ie you can access the National Council's database of third-level courses. From here you may find some relevant courses of interest to your specialist area and role. Some colleges and universities may offer “stand-alone” research modules, summer courses or online as well as distance education courses.
- Many skills can be gained or refreshed by keeping up to date through reading. The skills you require should include being able to interpret and apply research findings to your practice. Evidence-based practice (EBP) is a relatively new element of research utilisation. Its aims include enabling users of research to develop the skills of rapidly finding and appraising high-quality evidence relevant to their area of practice and particular circumstances. Many centres of nurse/midwife education (CNEs/CNMEs) and NMPDUs offer short EBP study days/workshops. Contact your local NMPDU or CNE/CNME to find out if you have a local EBP teacher whom you can link in with. Also you can log on to the website of the Centre of Evidence-Based Medicine (www.cebm.net) or the Irish site www.healthintelligence.ie to learn more about EBP.
- Other sources of support and links can be found on the research page of the National Council's website - www.ncnm.ie.
- The books and articles referenced in the bibliography to this resource pack, and the peer-reviewed nursing journals and websites listed in Appendix 8 are good sources of research information. Journal clubs are a good way of sharing the workload and sharing knowledge regarding best in class evidence in your specialist area.

Remember, your contribution to research may include working as part of a team on a research project or making suggestions for nursing research to the appropriate persons. Seeking support, especially if you are new to research, from others knowledgeable, involved and interested in research is also a good way of up-skilling yourself. Contributing to research may also mean identifying and sharing with others clinical/practice questions you would like answered so though you may not be in a position to undertake the research, others, possibly in academic or research positions may be interested in doing so; or if not they may know who is conducting research in that area.

4.8 SUMMARY

Audit and research are an important component of the CNS/CMS role. Audit gives a voice to the consumer, primarily concerns improving patient care and generates relevant information for practice. There is no single definitive audit methodology and there are many levels of audit activity ongoing in today’s healthcare environment to learn from. As a CNS/CMS it is important that you are able to demonstrate your effectiveness as part of your professional role in order to survive and thrive.

Research utilisation is inherent to the CNS/CMS role; often the challenges are to encourage others to implement research within practice. Contributing to nursing research may be time-consuming, or unfamiliar to you. If you are new to audit or else auditing a new topic, remember to ask for assistance and seek support.

Further Reading

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CHAPTER 5

The Clinical Nurse/Midwife Specialist and Report Writing

5.1 INTRODUCTION

A report can be any document on a given topic that informs and/or persuades the reader; analyses facts; presents explanations and sometimes, makes recommendations. It can be of varying length but should always be clear, concise, complete and correct. As a CNS/CMS, you may be required to provide various types of reports. The next section provides you with information on writing skills for an annual report. The processes and skills involved can be applied to most reports. Then, the information required for a CNS/CMS annual report is considered. The final section of this chapter concentrates on preparing a service plan submission.

5.2 SKILLS FOR WRITING AN ANNUAL REPORT

An annual report on your role and specialist services provides you with an excellent platform to explain your role to others in your service and organisation. The report provides you with a way to share your progress and achievement to date, while providing up to date information on your patient/client group, their particular needs and appropriate care. Don't be afraid to boast about achievement - remember, however, to give acknowledgement to others where due. If you have completed Chapter 2 of the resource pack, a lot of the information gathered there will be of use to you in planning and writing your report. It is important that the report you write is well structured, clear, concise and needs only to be read once to convey its message. As you can imagine, to achieve such a report requires planning and time to prepare, collect, analyse and finalise data. Data management should be a year-round occurrence rather than an end of year event. A possible framework/outline for report writing follows in Box 5.1.

Reading relevant publications such as annual reports written by others in your organisation will provide you with further information on report writing styles. Also, your organisation may have guidelines relating to corporate style. Such reports and guidelines may be available to view on your own organisation's website.

BOX 5.1: SUGGESTED OUTLINE/SEQUENCE FOR AN ANNUAL REPORT

Introduction/Foreword	• The report's purpose • Key background information • A brief outline of the contents • Definition of technical or specialist terms
Main body of the report	• Arrange to meet specific needs of the reader • Clarifying the nature of the situation which has prompted the need for the report • Discuss method of study, if relevant to report • Reveal the relevant facts/findings • Conclusion and recommendations • Summary of key points • References • Appendices

The following sections discuss the processes involved in report writing.

1. Scope

Agree purpose and limits for your specific report. What does the reader want and need to know? Do you need to obtain permission from any key stakeholders? What data will you require?

2. Information Collection and Collation

This can be quite time-consuming and will involve collecting the required data and analysing it. You will need to judge and sift through data you have gathered throughout the year, discard irrelevant and duplicated information and select, sort and arrange the required data in a logical sequence. Remember to keep to the scope of your report and seek clarification on issues you are unsure of. This type of information should be collected on a regular basis and analysed at intervals, as you may find it almost impossible if left until the end of year. In brief, when looking at information required for your annual report, remember to:

- Be prepared
- Focus on the end result
- Focus on the reader
- Focus on the facts
- Check what information you have already
- Identify what additional information you will require
- Identify where, when and how you will collect any additional information.

3. Writing first draft using suggested headings

Having decided the scope and limitations of your report, identify the key areas. Divide the report into sections, giving each key area its own subject headings.

4. Editing and Presenting the Final Report

Proof-read your report by asking others to read it. Edit and polish the language. Reference your report using a recognised method. Finally, publish it or disseminate it as appropriate.

5.3 GATHERING INFORMATION AND DATA FOR YOUR ANNUAL REPORT

When writing a report, allow sufficient time to plan and write it, but also to gather the relevant data. Leaving data collection and analysis to the year-end is stressful and will cause you to omit a lot of good data because you have forgotten about it! Regular note taking, data collection and analysis should be gathered and stored throughout the year. Items that may not seem very important at the time can later assume greater significance.

Items to record and collect are facts about your actual role activity throughout the year, including the nature of care provided and the number of patients seen by you in clinics, on ward/unit visits or during home visits. Also, try to keep track of telephone contacts with patients and their families. Keep a running total in your diary, on an Excel spreadsheet or in a ledger designed specifically for patient contacts and activity analysis. To simplify data gathering, consider formulating a simple coding system for your main activities. Add up coded types of activity each week. This makes data collection easier, faster and more compact.

You can develop your own coding system to review your daily activities. If you complete this for a fortnight or a month, you will hopefully have captured most of your regular activities. Examples of possible codes are shown in Box 5.2 below.

BOX 5.2: CODING DAILY ACTIVITIES

1. Clinical Focus		2. Patient Advocacy		3. Education & Training		4. Audit and Research		5. Consultancy	
1.1	Direct contact with patient	2.1	Group advocacy	3.1	Education - self	4.1	Clinical audit	5.1	Inter-disciplinary
1.2	Indirect contact	2.2	Individual advocacy	3.2	Education - patient	4.2	Role audit	5.2	Intra-disciplinary
				3.3	Education - staff				

6. Travel (please specify to which code the above travel was related)

7. Attending meetings (please specify to which code they related)

8. Other (please specify)

Appendix 1 (Option 2) presents you with a time log sheet, which you can use to develop your own codes. After a fortnight completing the sheets on a daily basis review your sheets and number or code each of your regular activities. It is these codes that you can record on a daily basis in your diary or ledger. Work out the frequency of codes on a weekly and monthly basis.

A possible template for your diary/ledger is suggested in Appendix 1 (Option 1). If you keep a regular tally of your activities in this way, you will then be able to clearly state where you are spending your time when it comes to writing your annual report or providing progress reports for your manager. You may also use this data to make comparisons and view trends in relation to your role activity from month to month and from year to year.

Remember to write down time spent on other activities and specify what these "other activities" are. They will help you recognise a new activity or changing trends emerging in your work patterns. You may prefer to use more specific codes in addition to or instead of those provided above, e.g., codes to cover all sub-types of activities such as educating nursing staff, educating healthcare assistants, educating medical staff, etc. Beware of using too many codes as this may become confusing. It may be more appropriate to keep separate records on areas such as the target population of your education and training sessions. You can collate this type of information from your sign-in sheets. Specific types of audit and evaluations that you have carried out or were involved in could also be collected separately. The number of codes and how you manage your coding system will depend on the frequency of your role activities and should become apparent to you after you carry out your time log sheets (Appendix 1, Option 2) for a fortnight.

In summary, effective and efficient data-gathering and collation throughout the year will make the process of report writing less stressful and time-consuming and more accurate. The following will help you plan, write and present your report successfully:

- Allow sufficient time
- Talk through your idea with a colleague or mentor
- Plan your work
- Keep good records
- Perform a literature search, if appropriate
- Keep language simple and clear. Sentences should be short and paragraphs and designed to highlight specific points

- Check grammar, tenses, spelling, punctuation and jargon
- Layout should be clear, sequenced, and encourage the reader to move to the main text
- Divide into sub-sections
- Introduce and summarise each section
- Ensure paragraphs flow together
- Support opinions with evidence
- Link references and citations into work
- Integrate diagrams and illustrations
- Use graphics and tables judiciously
- Use recognised referencing method
- All terms should be clearly defined
- Bibliography should include all referenced material and all other relevant material read
- Appendices should contain data not appropriate to main body of report e.g. data collection tools used, existing protocols, reports.

5.4 THE CLINICAL NURSE/MIDWIFE SPECIALIST'S ANNUAL REPORT

A suggested structure for the annual report of the CNS (Asthma) in our case study could include the following:

- Introduction - outlining the scope of the report
- Contents
- The service - Background information on your specialist service and need for the report
- A review of the year, using the five core concepts as sub-headings
- Future developments
- Summary and conclusions.

Introduction to CNS/CMS Annual Report

Introduce the report and put it in context by outlining what will be covered in the report so that the reader knows what to expect. This section is usually written last because you are then able to clearly state what is written in the main body of the report and thus ensure accuracy. Mary the CNS (Asthma) in our case study might provide general information on asthma nationally, regionally, and globally, including the related costs of asthma to the patient and/or the service/organisation. Cite the National Council's definition of the CNS/CMS to inform the reader that the report will utilise the five core concepts as headings.

Contents Page

If a document is longer than five pages, a contents list is required.

The Service

Provide background information on your specialist areas of practice and the service you provide to your patient/client group. Include information about yourself such as your qualifications and experience. You could also use this opportunity to link your role to the National Council's definition of a CNS/CMS, the five core concepts and any relevant national health strategy objectives, local organisational objectives or any benchmark sites or practices relevant to your area.

A Review of the Year

What you decide to put into the main body of the report will depend on the nature of your role, your priorities for the previous year and the audience you are preparing your report for. Using the five core concepts as sub-headings will provide an appropriate structure for all CNS/CMS annual reports.

1. Clinical Focus - Direct and Indirect Care

Provide information about direct and indirect patient/client care, to include:

- Details of type and number of patients seen. Plot out your activity on a monthly basis. Comment on change from previous years, deviations from norm or any activity you feel needs highlighting to the reader.
- Details of any evaluations of care or relevant findings from your role evaluations, e.g., patient outcomes relating to length of stay, waiting times to see the CNS/CMS or outcomes from any patient satisfaction survey you may have carried out in the previous year. Consider using quotes, if available, to illustrate your point. Quotes can be a very powerful tool to assist your reader's understanding of the situation.

2. Patient/Client Advocacy

Highlight activities that demonstrate your performance in the area of patient advocacy. The National Council has stated that the CNS/CMS role involves "communication, negotiation and representation of patient/client values and decisions in collaboration with other health care workers and community resource providers" (National Council 2007a p7). You probably regularly advocate for patients/clients on an individual and/or a group basis. Demonstrate how you represent or negotiate for patients/clients, perhaps at multidisciplinary team meetings, in accessing certain services, promoting self-advocacy or representing patients'/clients' views, values or decisions at other decision-making forums in the community or in your organisation.

3. Education and Training

Your education and training role occurs both formally and informally and could be presented under the following three sub-headings:

a) Self: Explain how you keep up to date and ensure evidence-based practice in your specialist area. Include study/training days but also any self-directed study or academic achievements in the past year. If you have completed a personal development plan (PDP), refer to this here.

b) Patient: Describe how you provide patient and family education. Provide details on number of sessions provided for patient and their families/friend and any evaluations of these sessions.

c) Staff Inform your reader about your role in "up-skilling" other staff so that they can provide direct care. Include types and frequency of education sessions; a profile of those taught, e.g., different grades and professions; and provide information on evaluation from training days. Also if you carried out a staff survey as part of your role evaluation add in any relevant findings that relate to your education and training sub-role.

4. Audit and Research

Include in your report any details of:

- Audits of your role, of your practice and the quality of patient care, including patient satisfaction surveys
- Needs assessments or service reviews
- Change(s) implemented in your practice or in patient care overall
- Research findings disseminated and/or implemented in relation to your specialist area
- Nursing/midwifery research contributed and/or initiated in your specialist area.

5. Consultancy

Discuss how you have carried out your consultancy role in order to improve patient management, at inter- and/or intra-disciplinary level. This may include your availability to others within your organisation and without. Include the type and source of consultation, whether they referred to specific clinical practice issues concerning a patient or were a more general educational consults in relation to your specialist area. Any developments on your referral criteria and/or referral pathway may be reported here.

Link any of your work that promotes the national health strategy goals and objectives to the relevant goal, objective and action. Also, if you have done any work in the area of performance indicators or benchmarking, you could include it under the relevant heading.

Future Developments

The CNS/CMS role is dynamic and should respond to patient/client care needs as well as organisational needs. It is important to provide evidence in your report of how you have taken a strategic approach to your role and specialist service development in order to improve patient/client care. You could include your action/operational plan for your role as an appendix or describe what plans you have prioritised to develop or expand your service. The annual report is an opportunity to provide your reader with information about your priorities for the coming year.

Summary and Conclusion

Readers tend to concentrate more at the start and the end of reports so provide a punchy summary of the key points. Include any relevant conclusions that can be supported by the information contained in the main body of your report. Your conclusion should provide an ending to the existing situation - where you are now and/or recommend a suitable course of action for the future.

Publishing and Disseminating your Report

Who you will circulate your report to has already been decided, as you have been writing the report with the reader in mind. Your report may be part of your organisation's annual report or you may have a more specific readership in mind, i.e., your manager and relevant clinicians. You may wish to have some copies available for your patients/clients. Whoever your readership, it is important that your report is presented in a clear, user-friendly manner. Check you have not broken the rules of report writing and get someone who has not seen drafts of the report to proof-read your report. Box 5.3 outlines a checklist for you and your proof-reader to keep in mind when proof-reading.

5.5 YOUR BUSINESS CASE SUBMISSION/BID

The last section of this chapter addresses writing a service plan/business case submission/bid, an area that can cause stress and confusion for many health professionals.

What you have learned from reviewing and evaluating your role to date may have highlighted an important area you would like to develop and that requires input, resources or approval from your organisation. This is when your line manager may request that you make a service plan submission/funding bid.

Devolution by the Department of Health and Children of the service planning process to health care providers means that service planning is now a key activity required of many managers and professionals. Butler and Boyle (2000) identified the service plan as being critical component of the accountability framework in terms of ensuring the provision of appropriate, effective and equitable services, and for the effective control of resources. Currently service planning within the HSE involves three levels of business planning. Level 1 is the regional plan (e.g., a business plan for a National Hospitals Office group or HSE region) in response to the HSE's corporate objectives and National

BOX 5.3: CHECKLIST FOR PROOF-READING YOUR REPORT

- Is the main body of the report consistent with the objective(s)?
- Is the flow logical and clear?
- Does the main body naturally lead the reader to the conclusions and recommendations?
- Are there sufficient headings to signpost the way?
- Have you supported your statements with evidence, when required?
- Has appropriate language and punctuation been used throughout?
- Does the report have the impact you wanted?
- Will people want to read it?

Business Plan. A level-2 business plan is an individual hospital/PCCC area plan in response to Level 1. A level-3 business plan is at service/department level. These business plans are not bids for additional resources but are a means of identifying targets and objectives for the year and service in question. You could be asked to do a level-3 plan for your service.

Previously within the HSE when looking for additional funding, each hospital developed service bids. This is no longer the case. Bids for service developments now go through the estimates process in September of each year in time for the production of the Department of Finance Estimates (Book of Estimates). Bids must be aligned with existing service or corporate, modernisation or reform strategies. The business case template for an estimates bid is outlined in Box 5.4. The purpose of your bid may be to secure additional staff or hours to deliver a more client-focused service in your specialist area or it may be a request for equipment to increase your effectiveness. Whatever the purpose, it is important that you are aware of the service planning process in your organisation and can participate when necessary.

The proposed development must be based on assessment of local need and should make sound business sense as well as being a safe, efficient and effective proposal that achieves health and social gain for your patient/clients. Your manager is your main support when developing a funding bid. When preparing a bid, it is important that you are aware of your own organisation's objectives and priorities and that you can link your proposed change to your organisation's priorities. It is also important in today's healthcare environment that your bid reflects external changes in the healthcare environment (e.g., health reforms and policies) and that the strategic direction of the service provider is in harmony with the DoHC's strategic directions.

All bids for developments have cost implications that require careful planning and negotiation. If your bid for proposed changes can demonstrate that these change will improve patient care and make savings or even provide an opportunity for income generation, then your proposed service development is likely to be welcomed by managers. Showing the long-term benefits of your bid and how it links in with your organisation's long-term strategic plans can be quite advantageous.

Demonstrating the benefits of your proposal requires that you include a business rationale in your bid. Draw on colleagues in the business planning, contracts, HIPE coding departments and information technology to supply and/or present appropriate supporting information, such as previous activity levels and costs relating to your patient/client group. Further evidence to support your case, e.g., information on current trends or cost-benefits, may be available from nursing and medical libraries. Colleagues in similar roles inside and outside of your

BOX 5.4 OUTLINE FOR BUSINESS CASE PLAN (Health Service Executive 2005)

- Service category and national directorate
- Description of service need to be met (linked to existing service plan objectives)
- Principal proposer and contact details
- Proposer's description of need in functional area (details of existing and future needs as appropriate)
- Proposed response to service need (description of response to defined quantum of service need to include identified benefits, proposed outcomes)
- Health impact assessment
- Cost of delivering proposal (includes funding available, human resource costs and other consideration - capital, infrastructure, equipping)
- Monitoring and reporting arrangements (who is responsible and accountable for delivery of the proposal?)
- Any additional information relevant to the proposal
- Decision (to be completed by National Director)
- Communication of decision to proposer

organisation can also be useful sources of information and give a wider perspective on services developments in your specialist area.

Business Plan Template

The business plan outline shown in Box 5.4 (HSE Corporate Planning and Control 2005) is a possible format to guide your service/business plan proposal/bid. Remember to check with your own local line manager, business or general manager for the template they use or require. They will also give guidance regarding the level of detail required in and relevant to your request/bid.

Submissions are sent via local management structures to the HSE and DoHC for approval. Funding is allocated each year via the Book of Estimates and approved allocated vote from the Oireachtas. Successful bids and allocation of funding are notified to your organisation via the DoHC or HSE. This letter is available to view in your organisation's annual service plan document. If your bid has been unsuccessful, follow up with your manager, find out what happened, and why it did not succeed. Also, find out is your bid worth re-submitting or are there any other ways resources could be made available for your proposal.

SUMMARY

The *Clinical Nurse/Midwife Specialist Role Resource Pack* is designed to assist you to reflect on, evaluate and develop your specialist role. Using tailor made tools, you are requested to clarify your role, identify areas for development and formulate plans to implement changes at a personal or service level. Throughout the resource pack the theme of the National Council's definition of the CNS/CMS and the five core concepts are highlighted as central to your role clarification, evaluation and development.

It is suggested throughout the pack that you involve peers and your line manger in your role development. The evaluation of the original resource pack indicated that the use and uptake of the pack was enhanced by the accompanying education programme. Where such a programme cannot be delivered we suggest that you avail of support from colleagues, other established CNSs/CMSs, line managers, professional development staff and practice development staff. The establishment of a CNS/CMS forum or network group can also be beneficial to individual CNS/CMSs to share learning and experiences. Having an educational focus to the group can help you meet some of shared learning needs.

A main objective of the resource pack is to assist you to articulate and demonstrate your effectiveness. This is very important for patients/clients, nurses/midwives and your organisation; especially so in this time of change for nursing/midwifery and our health services. It is recognised that there are many complex issues associated with role development and that the nature of the work undertaken by CNSs/CMSs must develop in response to the needs of patients and clients.

Finally, it is expected that this pack will be a dynamic resource tool that will change and evolve as your specialist roles develop. It is hoped and expected that you will utilise and adapt the resource pack during the lifetime of your specialist role. We will keep you updated, through the National Council's website, of any changes to the resource pack. If you have any comments, queries or ideas for development of this resource pack, please do not hesitate to contact me.

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APPENDIX 1

Time Log Sheets and Diary

INTRODUCTION TO OPTIONS 1 AND 2

In Appendix 1, there are two options for your activity analysis sheet.

Option 1 is to maintain a ledger of your activities using a code system to make data collection and analysis easier (read pages 76 and 77 for further instructions)

Option 2 is a time log sheet. If you have never kept any activity analysis, it may be easier to start with this option. Though it was developed as a time management tool, it is useful to gather information on where you are spending your time. After writing down your activities for a fortnight or a month, you can then group them under the five core concepts. This allows you to estimate amount of time you spend under any core concept. For more information on the time log sheet, read Section 5.3.

OPTION 1. EXAMPLE OF ACTIVITY SHEET FOR CONTACT ANALYSIS LEDGER/DIARY

Appendix 1. Option 1. Example of Activity Sheet for Contact Analysis Ledger / Diary

(Tick box or insert length of time as appropriate)
CNS_____ Month _____

id Code/ Activityno.	Fname	Sname	Medical No.	Address	In-Pt	OPD	Telephone consulta-tion	New Pt.	Re-admission	Recalltoclinic	HospLengthof stay	AcuteLengthof stay(ICU/HDU)

id Code/ Activityno.	Fname	Sname	MedicalNo.	Education Patient /Family	Education of Staff	Education (other)	Other	Length of Consultation /Session

OPTION 2. TIME LOG DIARY (Change Management Training Ltd 2002)

A Word version of this time log diary is available on the CD-ROM accompanying this pack. Copy the attached time log sheet and complete for at least a period of two weeks.

How to Fill Out your Time Log

- Fill out as you are going along, do not wait until the end of the day and hope that you will remember exactly what you did during the day. Accuracy is important.
- Fill out one sheet per day (or more if required). Do not have more than one day on any sheet.
- Identify in the space marked Main Goal (s) what you have planned to achieve on that day. Fill this out either the previous evening, or the first thing in the morning, before undertaking any activity.

Column 1 Enter the start time of the activity.

Column 2 Enter a brief description of the activity you are doing.

Column 3 Enter the time the activity was finished.

Column 4 Leave this column blank (Fill in at analysis stage).

Column 5 Be very critical in this column. Could you have delegated this activity?

Column 6 Enter the time that could have been saved if this activity could have been delegated, or if you had handled it more effectively than you possibly did.

Column 7 Identify if this was a planned activity or if it was what we would consider an interruption or unplanned event.

Analysis

After the two-week stage, review your time log sheets.

Consider:

- Are these activities truly helping me achieve my role purpose?
- Can I relate the activities to the five core concepts of the CNS/CMS role?
- Did I do everything I needed to do?
- Did I have enough time to do the things I wanted to?
- When was I most productive/least productive?
- Did I accomplish the most important things?
- Did I have to do all of these things or could I have effectively delegated any?

Assign priorities to the activities carried out each day; top up time spent on high, medium and low priorities.

Note your top five time wasters.

Develop an action plan to deal with them.

Post your plan where you can see it.

This time log sheet is used as part of the time management module in the CNS/CMS development programme. Briefly, time management can be visualised in terms of three interlocking circles:

OPTION 2. TIME LOG SHEET

TIME LOG SHEET				**Date:**		
Main goal(s) for the day:						
Start Time	**Description of Activity**	**Finish Time**	**Priority** H/M/L	**Possible to Delegate** Yes/No	**Possible Savings** (hrs)	**Interruption** *Yes/No*
		Total Hours				**% of Day**

APPENDIX 2. ACTIVITY/CONTACT ANALYSIS SHEET

A Word version of this activity/contact analysis sheet is available on the CD-ROM accompanying this pack.

		Time Spent (on a scale of 0-5)	***Importance to Role*** (on a scale of 0-5***)***
		0 = no time 5 = a great deal of time	0 = of no importance 5 = of very high importance
Clinical Focus			
Clinical Focus			
Direct contact with patients/clients	Individuals		
	Groups		
Direct contact with other nurses about patients/clients			
Direct contact with doctors about patients/clients			
Direct contact with other healthcare professionals about patients/clients			
Direct contact with other non- healthcare professionals about patients/clients			
Telephone advice	Patients/clients		
	Healthcare professionals		
Patient Advocacy			
Individual patient/client basis			
Group basis			
Education and Training			
Patient/client and family education			
Teaching/training other colleagues and other health professionals			
Self/personal/professional updating			
Audit and Research			
Participating in audit			
Participating/contributing to research			
Consultant			
Internal Consultations			
External Consultations			
Add your own activities in these blank lines if relevant or not counted in the above key performance areas			
Administrative/clerical (arranging meetings, writing notes, reports, filing, photocopying etc.)			
Travelling			

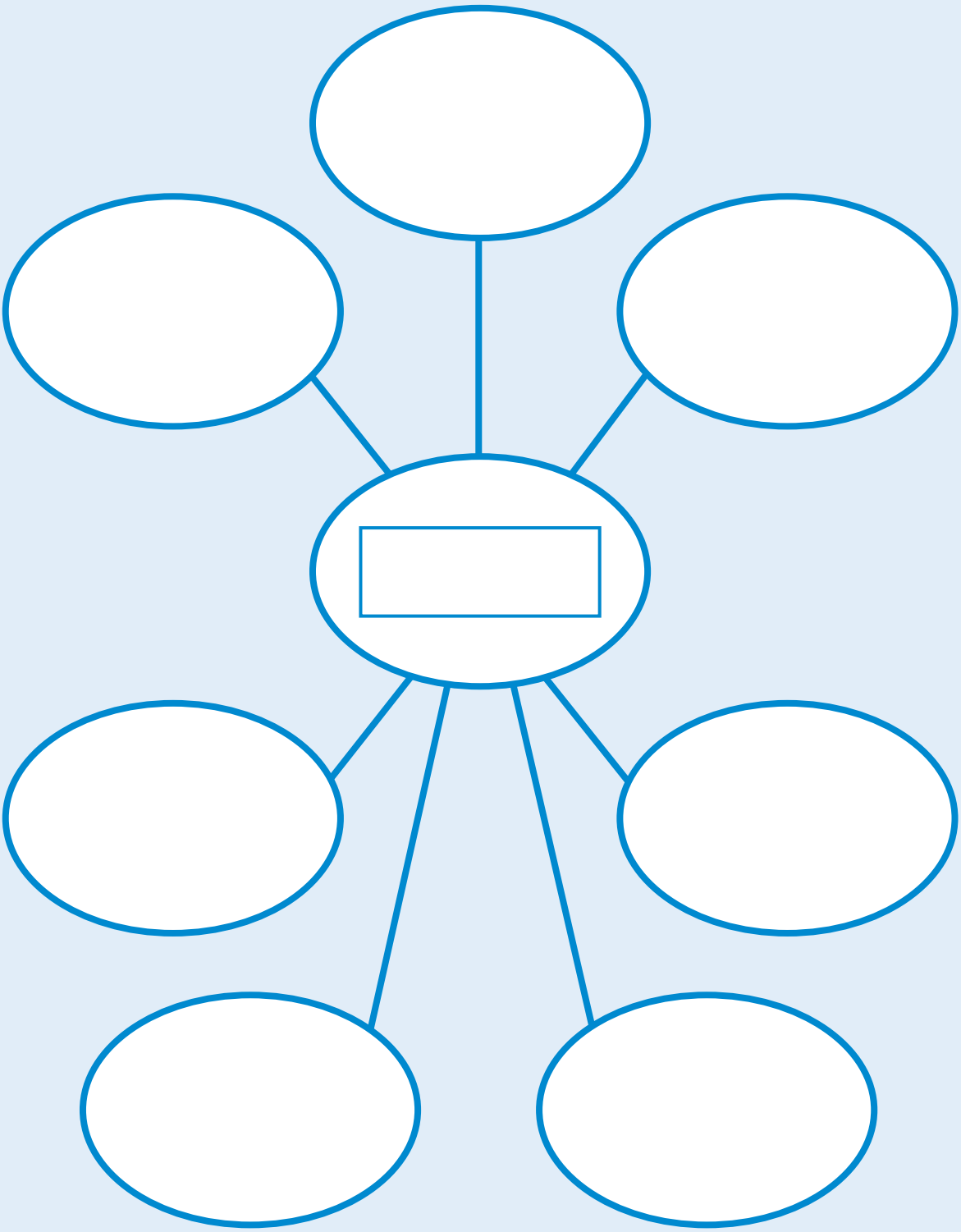
Activity/Contact Analysis Sheet (Blank)

	Time Spent (on a scale of 0-5) 0 = no time 5 = a great deal of time	***Importance to Role*** (on a scale of 0-5) 0 = of no importance 5 = of very high importance
Clinical Focus		
Patient/Client Advocacy		
Education and Training		
Audit and Research		
Consultant		
Add your own activities in the blank lines: Remember most of your activities should fit under a core concept heading, if they relate to your specialist role purpose		
Administrative/Clerical (arranging meetings, writing notes, reports, filing, photocopying etc)		
Travelling		

APPENDIX 3. NETWORK DIAGRAM

You can use this framework, or simply start with a blank sheet of paper and improvise! Alternatively, this activity sheet is available on the CD-ROM accompanying this pack.

NETWORK DIAGRAM



APPENDIX 4. REVIEWING OR FORMULATING A MISSION STATEMENT

A Word version of this mission statement review sheet is available on the CD-ROM accompanying this pack.

Option 1: REVIEWING YOUR EXISTING MISSION STATEMENT (Change Management Training (CMT) Ltd 2002)

Thinking about what an effective mission statement is setting out to achieve, review your existing mission. Use the following questions to assist you in your review.

Q.1 Is your mission statement inspirational in the way it presents the future?

Q.2 Is it clear and challenging?

Q.3 Can it be used to help you focus?

Q.4 Does it provide you with a framework which you can use to develop organisational goals and objectives?

Q.5 Can you see evidence in your role that shows the mission statement in action?

Q.6 Can you identify if your mission statement displays the following characteristics that effective mission statements should have?

Characteristic	Yes	No
Customers	❑	❑
Concern for continuous quality improvement	❑	❑
Philosophy of the organisation	❑	❑
Self-concept	❑	❑
Concern for public image	❑	❑

Q.7 What actions need to be taken to make your mission statement more effective?

Option 2: FORMULATING A COMPELLING MISSION STATEMENT (CMT Ltd 2002)

A Word version of this mission statement review sheet is available on the CD-ROM accompanying this pack.

The following questions may help you to focus on and develop your own mission statement. Imagine that this statement is going to be presented to all of your stakeholders.

Q.1 Why does your role exist/what is its reason for being?

Q.2 Who are your stakeholders? What do each of them want from you?

Q.3 What does your organisation want you to be especially good at doing?

Q.4 What changes do you expect to see in the demand for your services over the next five years?

Q.5 What criteria do you use to judge success and how well are you satisfied that you are measuring important criteria?

Q.6 How do your clients/customers view the quality of the service you deliver?

Q.7 How do you want your clients/customers to be able to view the quality of what you deliver?

YOUR COMPELLING MISSION STATEMENT

APPENDIX 5. TEMPLATE FOR SETTING SHORT-, MEDIUM- AND LONG-TERM OBJECTIVES (CMT Ltd 2002)

A Word version of this template for setting objectives is available on the CD-ROM accompanying this pack.

Take each of the critical success factors (CSF) in turn and identify where you would like to be in each area in five years' time. Then develop the objectives for the medium- and long-term in each area.

Remember your objectives should be SMART: Specific, Measurable, Achievable, Relevant and Time-bound.

Critical Success Factor

Where would you like to be in five years' time with this CSF?

Medium-term objectives for this CSF

Short-term objectives for this CSF

APPENDIX 6. TEMPLATE FOR COMPLETING AN OPERATIONAL PLAN

A Word version of this template for completing an operation plan is available on the CD-ROM accompanying this pack.

Core Concept or Critical Success Factor

Service Plan Reference (if relevant/appropriate)

Operation Plan Reference

KEY PRIORITY

WHAT ARE THE KEY ACTIONS TO BE TAKEN IN IMPLEMENTING THIS PRIORITY?

WHEN WILL IT BE IMPLEMENTED?

WHO WILL BE RESPONSIBLE FOR IMPLEMENTATION?

IF NOT EXPECTED TO BE COST NEUTRAL, IDENTIFY FUNDING SOURCE

MEASUREMENT CRITERIA /PERFORMANCE INDICATORS

REVIEW DATES

APPENDIX 7. PERSONAL DEVELOPMENT PLAN TEMPLATE (CMT Ltd 2002)

(ONE PLAN PER COMPETENCY/DEVELOPMENT NEED)

Competency to be addressed

Related core concept

Target outcome (give a clear description of what you will be able to do once you have addressed this competency)

Specific steps

Steps I will take	Expected completion date

How will you measure your success?

Ways you will be able to utilise this competency

Support you will need to develop this competency - whose support do you need and how will you obtain it?

How will you measure your progress?

Review dates

Signed:	Date:

APPENDIX 8. USEFUL INTERNET WEBSITES[1]

Nursing and Midwifery in Ireland

www.ncnm.ie
The website of the National Council for the Professional Development of Nursing and Midwifery: includes a CNS/CMS section; hosts many specialist groups' websites; includes an events, publications and research section as well as a useful links section and a database of third-level education courses.

www.nursingboard.ie
The website of An Bord Altranais (the Irish Nursing Board) contains many useful resources for nurses and midwives.

Evidence-Based Practice Websites

Evidence-Based Nursing (EBN)
www.evidencebasednursing.com is one of several BMJ Publishing Group websites and surveys a wide range of international medical journals applying strict criteria for the quality and validity of research. EBN can also be accessed free from the National Council's website **(www.ncnm.ie)** or via an Athens account. Other relevant BMJ Publishing Group sites include:

Quality and Safety in Health Care - http://qshc.bmj.com/

Evidence-Based Mental Health - http://ebmh.bmj.com/

Evidence-Based Medicine - http://ebm.bmj.com/

BMJ Clinical Evidence - http://clinicalevidence.bmj.com/ceweb/index.jsp.

The **Centre for Evidence-Based Nursing** (CEBN)
www.york.ac.uk/healthsciences/centres/evidence/cebn.htm at the University of York, England is concerned with furthering evidence-based nursing through education, research and development.

The **TRIP Database**
http://www.tripdatabase.com/healthcarequality/index.html uses the principles of evidence-based medicine to answer clinical questions. This website has useful specialist sites, patient information leaflets and links to other EBM sites.

Bandolier
www.medicine.ox.ac.uk/bandolier/ was originally an independent journal about evidence-based healthcare and is now a website with a good EBM glossary and an Oxford Pain site.

The **Joanna Briggs Institute** (JBI)
www.joannabriggs.edu.au/about/home.php is an international collaboration involving nursing, medical and allied health researchers, clinicians, academics and quality managers across forty countries.

Introduction to Evidence-Based Medicine
www.hsl.unc.edu/Services/Tutorials/EBM/welcome.htm is an on-line tutorial intended for any health care practitioner or student who needs a basic introduction to the principles of EBM.

The **Centre for Evidence-Based Medicine**
www.cebm.net aims to develop, teach and promote evidence-based health care and provide support and resources to anyone who wants to make use of them.

[1]Please note that the authors of the *Clinical Nurse/Midwife Specialist Role Resource Pack* cannot guarantee the accuracy, currency or completeness of the information contained on the suggested websites.

Best Bets
www.bestbets.org/ was developed in the Emergency Department of Manchester Royal Infirmary, England, to provide rapid evidence-based answers to real-life clinical questions, using a systematic approach to reviewing the literature.

The **National Guideline Clearinghouse™** (NGC)
http://www.guideline.gov/ is a public resource for evidence-based clinical practice guidelines.

Research Websites

The **Health Research Board** (HRB)
www.hrb.ie is the lead agency in Ireland supporting and funding health research. This site also hosts free access to the Cochrane Library - no fee or passwords required.

The **Irish Clinical Research Infrastructure Network**
www.icrin.ie/index.cfm aims to fill gaps needed to develop a world-class clinical research capacity in Ireland.

The **National Institute of Health Sciences**
www.nihs.ie/nindex.cfm aims to create enduring partnerships between professional and academic bodies and the statutory provider of health and personal social services in Ireland. Click "research guidance" for useful tools on research.

Libraries

Health Service Executive (HSE) Libraries On-line
www.hselibrary.ie provides access for HSE staff to quality electronic resources, databases and library catalogues. Additional electronic resources may be available via your local HSE library. Please refer to the Directory of Libraries. Irish health publications including HSE and former health board publications are available in the Irish Health Publications archive.

The **Consortium of Irish Universities and Research Libraries** (IRIS)
www.iris.ie provides access to several national and international third-level education and other libraries.

The **National Library for Health** (NLH)
http://www.library.nhs.uk/ provides access to evidence-based reviews, guidelines and specialist libraries. NLH hosts the NHS Clinical Knowledge Summaries (formerly PRODIGY), a reliable source of evidence-based information and practical "know how" about the common conditions managed in primary care.

PubMed
www.ncbi.nlm.nih.gov/sites/entrez/ is a database of citations from MEDLINE and other life science journals for biomedical articles dating back to the 1950s and developed by the National Centre for Biotechnology Information.

CHAIN (Contact, Help, Advice and Information Network)
chain.ulcc.ac.uk/chain/ is an on-line network for people working in health and social care, providing a simple and informal way of contacting each other to exchange ideas and share knowledge.

Audit

University Hospitals, Bristol (UH Bristol) Clinical Audit Central Office
www.uhbristol.nhs.uk/healthcare-professionals/clinical-audit/how-to-guides.html has produced several clinical audit guides. NB, if you use the guides, ensure that UH Bristol is clearly credited on the materials (which are subject to copyright).

The **National Institute for Health and Clinical Excellence** (NICE)
www.nice.org.uk/ has produced *Principles for Best Practice in Clinical Audit,* available to download from
www.nice.org.uk/otherpublications/bestpracticeinclinicalaudit/principles_for_best_practice_in_clinical_audit.jsp

The **NHS Clinical Governance Support Team** (CGST)
http://www.cgsupport.nhs.uk/ has produced *Practical Handbook to Clinical Audit.* Search "clinical audit" for the publication.

The **Healthcare Commission**
www.healthcarecommission.org.uk/ is the independent watchdog for healthcare in England and hosts information about NHS national audits and some further information and tools on audit.

The **NHS Institute for Innovation and Improvement**
www.institute.nhs.uk/ supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and leadership. Follow the quality and value and safer care links for examples of projects and improvement tools.

The **National Patient Safety Agency**
http://www.npsa.nhs.uk/ leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.

The **Institute for Healthcare Improvement** (IHI)
www.ihi.org/ is an American independent not-for-profit organisation concerned with leading the improvement of health care. Click on "topics" to find information on improvement tools, change, leadership and patient safety.

The **Agency for Healthcare Research and Quality**
www.ahrq.gov has produced *Patient Safety and Quality: An Evidence-Based Handbook for Nurses,* available to download from http://www.ahrq.gov/qual/nurseshdbk/.

Other Health-Related Websites

Department of Health and Children - **www.dohc.ie**

Health Data - **http://www.health-data.info/v2/default.asp**

Health Intelligence - **www.healthintelligence.ie/**

Health Service Executive (HSE) - **www.hse.ie**

HSE Health Promotion - **www.healthpromotion.ie/**

HSE Learning and Development - **www.hseland.ie**

Irish Health - **www.irishhealth.com/**

Irish Society for Quality and Safety in Healthcare - http://www.isqsh.ie/

Medscape - **www.medscape.com**

Medicine Net - **http://www.medicinenet.com/health_and_living/focus.htm**

Mental Health Commission, Ireland - **www.mhcirl.ie**

NHS Direct - **www.nhsdirect.nhs.uk/**

Patient UK - **www.patient.co.uk/**

Voluntary Health Insurance (VHI) Healthcare - **www.vhi.ie/atoz/index.jsp**

General Search Engines

Google - **www.google.com.** Try accessing Google scholar and Google books from here.

Alta Vista - **www.altavista.com.**

Meaning of website address endings on website names

.ac.uk - used by academic tertiary education and research institutions in the United Kingdom

.com - limited company

.edu/ - third-level institution

.gov - government body

.ie - Irish website

.info - provider of info

.int - intergovernmental (e.g., WHO, UN, EU)

.net - provider of services

.org - voluntary groups

APPENDIX 9. TIPS ON DESIGNING A QUESTIONNAIRE

Designing and Administering Questionnaires

Before designing your questionnaire you should have planned, consulted and decided exactly what you want or need to find out. Only then will you know if a questionnaire is suitable to yield useful data.

Care has to be taken in selecting question type, in question writing, in the design and piloting, distribution and return of questionnaires.

Thought must be given as how responses will be analysed during the design phase. The more structured a question, the easier it will be to analyse.

Youngman (1986) lists the following seven types of question types:

Unstructured

Verbal or open	The expected response is a word, phrase or comment. Content analysis may be required unless the information obtained is being used for special purposes (e.g. further topics for interviews).

Structured

List	A list of items is offered (respondents may tick more than one qualification).
Category	The response is only one of a given set of categories, e.g., age.
Ranking	The respondent is asked to place something in rank order, e.g., qualities or characteristics.
Scale	• Nominal • Ordinal • Interval • Ratio *These require careful handling during analysis.*
Quantity	The response is a number (exact or approximate) giving the amount of some characteristic.
Grid	A table or grid is provided to record answers to two or more questions at the same time.

Wording Questions

Wording should be precise, clear to remove ambiguity (i.e., jargon-free) Also if the information is not essential to the study - leave it out.

Q.1 How much time, on average do you spend on studying? Please tick (√) appropriate box.

A great deal? ❑

A certain amount? ❑

Not at all? ❑

Different respondents may have different views on what is meant by "a great deal." You could ask them to choose from different numbers of hours per week.

If respondents are confused or hesitate over an answer, they may pass on to the next question. You want answers to all questions, so try and avoid confusion.

The following example looks straight forward. Or does it?

Q.2 Which type of school does your child attend? (please tick)

Infant school ❑

Primary school ❑

Comprehensive school ❑

Grammar school ❑

Other (please specify) _____

There is an assumption you have only one child. Change to a category response.

Avoid over-reliance on memory if it is addressing an area respondents have not dealt with recently. Take care to avoid asking questions which ask for information the respondent may not have readily at hand.

Never ask a double question.

For example: *Do you spend time on audit and research?*

Is a *yes* answer yes to one or both?

Avoid leading questions, where it might be difficult for the respondent to disagree.

For example: *Do you not agree that.....?*

Be aware of presuming questions, e.g. *Does the university/health board make adequate provision for counselling?*

You are presuming they should provide counselling when some respondents may not think that university/college should provide the service.

Avoid hypothetical questions if possible.

For example: *If you had no responsibilities and plenty of money, what would you do with ...?*

Likely to be wrongly answered by respondents (but I do have responsibilities...)

Do not use offensive questions

If you do include a sensitive issue you must put in the questionnaire, consider the wording and positioning of the question especially carefully, usually positioned to the end, e.g., questions relating to age.

Appearance and Layout

- Tidy, typed (or printed if large survey)
- Instructions should be clear in capitals or different type
- Spacing between the questions will help the reader and also when you analyse responses
- If you want to keep the questionnaire to a limited number of sheets it may be better to photo-reduce copy
- Keep any response boxes aligned towards the right of the sheet
- If you intend to use a computer programme, allow space on the right of the sheet for coding
- Look critically at the questionnaire and ask yourself what impression it would give if you were the recipient
- Take care over the order of the questions. Leave sensitive ones to later in the questionnaire. Start with straight forward, easy to complete questions and move on to more complex topics.

Sample Size

Sample size often depends on the time you have, the topic and the population you wish to study. In large surveys, sampling techniques will be employed in order to produce a sample which is, as far as possible, representative of the population as a whole, therefore generalisations can be made.

Remember, you are dependent on the goodwill and the availability of subjects - often in small studies it is hard to achieve a true random sample. Opportunity samples are generally acceptable as long as the make-up of the sample and limitations of the data are realized. However you should try and select a sample as representative as possible. Random sampling means each individual has an equal chance of being selected, e.g. alternate names on an alphabetical list (it is wise to have reserve names).

You may wish to have representative sub-group (age, gender). For example:

- Total population = 100; number of men = 60; number of women = 40;
- Survey population = 50; number of men = 30; number of women = 20.

Piloting the Questionnaire

Test how long it takes to complete all questions and that all questions and instructions are clear. Try out on a group similar to the one that will form the sample population of your study. Carry out preliminary analysis to see if the wording or format will present any difficulties when the main data is analysed and that the questions are producing the expected answer types, i.e., respondents are answering the question asked as you intended.

Ask your pilot group other information on the questionnaire. For example:

1. How long did it take to complete?
2. Were the instructions clear?
3. Were any of the questions unclear or ambiguous? If so, will you say which and why?
4. Did you object in any way to answering any of the questions? If so, which and why?
5. In your opinion, has any major topic been omitted?
6. Was the layout of the questionnaire clear/attractive?
7. Any comments?

Distribution and Return of Questionnaires

You are likely to gain better co-operation if you establish personal contact. Try using internal mail to reduce costs; postal surveys are expensive and response rates are generally low.

Unless you are meeting subjects face to face, a letter is required explaining the purpose of the questionnaire, that approval has been given and what will be done with information provided. Return of the completed questionnaire implies consent to use data as outlined in the letter.

Give a return date - two weeks is a reasonable length of time for completion - give a precise day and date. Include an SAE if respondents have to return questionnaire by post.

Record date sent out and date returned - if you decide to follow-up non-respondents, a second letter with a questionnaire will be sent out. If you do not ask for names to be given or devise some system of numbering, you will have no way of knowing who has replied and who has not. If you promise anonymity - there is no way of linking response rate with individuals, and you may consider a blanket reminder to all possible respondents. A high non-response rate distorts results. Write out a week after return date. In large studies, a third or fourth reminder may be sent, though the yield at this stage may be low.

Further Reading for Information on Questionnaires

Cormack D. F. S. (Ed) (2000) *The Research Process in Nursing* (4th edn). Blackwell Science, Oxford.

McGibbon G. (1997) How to avoid the pitfalls of questionnaire design. *Nursing Times* 93(19), 49-51.

Parahoo A. K. (1997) *Nursing Research: Principles, Process and Issues*. Palgrave Publishers LTD, New York. (Chapter 11: Questionnaires, pp246-280).

Polit D. F., Beck C. T. & Hungler B. P. (2001) *Essentials of Nursing Research: Methods, Appraisal and Utilization* (5th edn). Lippincott, Philadelphia (pp267-270 & 86).

APPENDIX 10. PATIENT/CLIENT QUESTIONNAIRE

A Word version of this questionnaire is available on the CD-ROM accompanying this pack.

CASE STUDY: MARY - CNS (ASTHMA) *PATIENT QUESTIONNAIRE* (Hartley & Cowe 1997)

My name is _____ and I was your asthma specialist nurse during your recent stay in hospital. I am always keen to ensure that the service I provide meets the needs of my clients. Please help me to improve by completing the following questionnaire. Your replies are anonymous, but if you wish to put your name on the sheet please feel free to do so.

1. Some information about you

Please tick the relevant box:

Your age: 0 - 16 ☐ 17 - 30 ☐ 31 - 45 ☐ 45 - 60 ☐ 60 plus ☐

Your gender: Male ☐ Female ☐

When was your asthma diagnosed?_____

2. Your views on the services provided by the asthma specialist nurse.

How helpful was the information about asthma you were given by the asthma nurse specialist?

Good, complete and easily understood ☐

Average, all right but could have been better ☐

Unsatisfactory, incomplete and confusing ☐

What impact has this information had on your confidence in managing your asthma?

I feel more confident and independent ☐

It has made no difference ☐

I feel less confident ☐

3. Please circle any words from the selection below which describe the care you received from the asthma specialist nurse?

Supportive Bossy Not enough contact Crucial to my recovery Poor Wonderful Sensitive Irrelevant Adequate Easy to contact Unhelpful Rushed Considerate Friendly Invaluable Difficult to contact Condescending Informative Promoted independence Professional

4. Are there any other comments you would like to make?

_____

_____

_____

5. Do you have any suggestions for improvements in the service?

_____

_____

_____

Extra question from pilot group

6. Was there any topic not covered that you would have liked to discuss with the Nurse Specialist?

_____

Please return by (allow 7-10 days) in SAE to (name appropriate Dept/collection point) by (day & date).

Thank-you for your help in completing this questionnaire

APPENDIX 11. NURSING STAFF QUESTIONNAIRE

Confidential

Please help me evaluate the asthma specialist nurse service. All replies will be treated in confidence, with only summary data being reported with anonymised quotes.

Please tick the appropriate boxes.

1.0 Have you recently cared for a patient with asthma?

Yes ☐ No ☐

1.1 If yes, approximately how long ago was your most recent contact?

a) Less than 3 months ago ☐ b) Between 3 and 6 months ago ☐

c) Between 6 and 12 months ago ☐ d) Between 12 and 18 months ago ☐

e) More than 18 months ago ☐

2.0 What position/role were you in when you had this most recent contact? _____

3.0 Do you know who the asthma specialist nurse is?

Yes ☐ I think I know ☐ I'm not sure ☐ No ☐

4.0 Have you met the asthma specialist nurse?

Yes ☐ No ☐

5.0 Do you know how to contact the asthma specialist nurse?

Yes ☐ No ☐

6.0 Have you ever attended any formal training given by the asthma specialist

Yes ☐ No ☐

6.1 If yes, did you find this training relevant to your work?

Yes, definitely ☐ Yes, most of it was relevant ☐

Some of it ☐ Not much of it was relevant ☐

No, it wasn't relevant ☐

6.2 If you didn't think it was relevant why not?

_____

_____

_____

_____

_____

_____

7. 0 Has the asthma specialist nurse ever given you any advice concerning the care of an asthmatic patient?

Yes ☐ No ☐

7.1 If yes, did you find this training relevant to your work?

Yes, definitely ☐ Yes, most of it was relevant ☐ Some of it ☐

Not much of it was relevant ☐ No, it wasn't relevant ☐

7.2 If you didn't think it was relevant why not?

_____

_____

8.0 If you have had either formal training, or advice from the asthma specialist nurse do you feel you have a greater understanding of the needs of asthmatic patients?

Yes ☐ Not particularly ☐ No ☐

8.1 If no, please explain why not.

_____

_____

9.0 Are there any topics you would like the asthma nurse specialist to train/advise on? If yes, please list topics.

_____

_____

10. If you have ever had cause to contact the asthma specialist nurse, was she:

Easy to contact ☐ Fairly easy to contact ☐

Fairly hard to contact ☐ Very hard to contact ☐

11. What is the best aspect of the service the asthma specialist nurse provides?

_____

_____

12. What is the worst aspect of the service the asthma specialist nurse provides?

_____

_____

Please comment on any other aspects of the service the asthma nurse provides:

_____

_____

Thank you for taking the time to complete this questionnaire.

Please return to the Clinical Audit Department / appropriate collection point by -day & date

APPENDIX 12. CLINICIAN'S QUESTIONNAIRE

Strictly Private and Confidential

Clinicians' Questionnaire - Asthma Nurse Specialist (Hartley & Cowe 1997)

A generic Word version of this questionnaire is available on the CD-ROM accompanying this pack.

Please tick the appropriate boxes.

1. **Has the asthma specialist nurse been involved in the care of your patients?**

   Yes ☐ No ☐

2. **Do you think the services currently provided improve the quality of patient care ?**

   Yes ☐ To some degree ☐ No ☐

3. **Which services currently offered by the asthma specialist nurse nurse do you feel make the greatest impact on the quality of patient care ?**

   _____

   _____

   _____

   _____

4. **What other services would you like to see offered by the asthma specialist nurse?**

   _____

   _____

   _____

   _____

5. **Do you think the Specialist Nurse facilitates discharge ?**

   Yes ☐ To some degree ☐ No ☐

6. **Please make additional comments about the service the Specialist Nurse provides:**

   _____

   _____

   _____

   _____

Thank you for taking the time to complete this questionnaire.

Please return to: _____ *by:*_____

day and date: _____

APPENDIX 13. CLINICAL NURSE SPECIALIST ROLE AUDIT

A Model for CNS Evaluation* (Hamric 1989, pp98-100) *Use of Donabedian's Model in Evaluating CNS Goal

Goal: To facilitate discharge planning and continuity of care through implementing primary nursing on a surgical unit.

Structure: (Focus: Did the intervention occur? In this case, was primary nursing implemented?)

Objectives:

1. Educational sessions on primary nursing are held.
2. Guidelines are developed for primary nurses and associate nurses.
3. The unit employs sufficient numbers of RN staff to implement primary nursing.
4. Patients are able to identify their primary nurse.
5. The primary nurse is identified on the patient's chart and an assessment is made of each patient within 24 hours of admission.

Process: (Focus: What is the quality of the primary nursing model? How well is primary nursing being practised?)

Objectives:

1. Staff satisfaction improves after introduction of primary nursing.
2. Quality of staff's use of nursing process improves after model is implemented.
3. Staff evaluations of educational sessions are positive.
4. Staff turnover and absenteeism both decrease after introduction of primary nursing. (See Kent and Larson [1983] for additional structural and process measures.)

OUTCOME: (Focus: What difference did the model make for patients?)

Objectives:

1. Patients on the primary unit have a decreased length of stay compared with similar patients (controlling for such variables as acuity and age) on the unit before primary nursing was implemented.
2. Patient satisfaction with nursing care increases compared with satisfaction before implementation.
3. Patients demonstrate more knowledge about their home care requirements than did similar patients on the unit before primary nursing was implemented.
4. The number of postoperative complications experienced by patients decreases after the introduction of primary nursing.

Guidelines for Developing an Evaluation Strategy for Individual CNSs		
	Example # 1	Example #2
Steps in Process	(One Major Focus)	(One of a Number of Foci)
1. Select focus (or foci) of practice	1. CNS to develop teaching programme for spinal cord-injured	1. CNS to identify patients educational needs of surgical nurses and provide appropriate in- service education for all shifts
2. Set goals, desired end results	2. CNS sets two goals: a. Nursing staff will accept and implement programme (nursing staff outcome)	2. 80% of all staff will participate in in-service programmes at least once a month
	b. Patients will have increased knowledge and increased ability to perform self-care (patient outcome)	
3. Determine whether structure, process or outcome evaluation is indicated	3. a. Structure	3. a. Structure
	b. Process	b. Process
	c. Outcome - cognitive and behavioural objectives	
4. Determine appropriate method and measure(s)	4. a. Record of numbers of staff available for programme -Administrative support- materials, time, etc -Audit reward system of unit-positive reinforcement for staff implementation	4. a. Time schedule - adequate staffing to allow attendance -Administrative support - materials, & setting
	b. Questionnaire to staff - to determine attitude(s) about programme - Evaluate nursing records process audit)- to determine no. of staff implementing and no. of documented teaching sessions	b. audit nursing records - programme topics, attendance; questionnaire to staff - to evaluate topics appropriate for their educational needs
	c. Questionnaire to patients - test knowledge - Test self-care abilities and compare with patients before the programme was implemented	
5.Determine appropriate evaluator(s)	5. CNS to collect audit data, business office data; survey nursing staff; and test patients	5. CNS to collect audit data, survey nursing staff
6. Determine appropriate intervals for measurement	6. One year after programme implementation	6. Six-month intervals

Identifying, Defining and Examining your CNS/CMS Role

National Council for the Professional Development of Nursing and Midwifery

An Chomhairle Náisiúnta d'Fhorbairt Ghairmiúil an Altranais agus an Chnáimhseachais

Feidhmeannacht na Seirbhíse Sláinte
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