National Council for the Professional Development of Nursing and Midwifery

An Evaluation of the Effectiveness of the Role of the Clinical Nurse/Midwife Specialist

National Council for the
Professional Development
of **Nursing** *and* **Midwifery**

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

JANUARY 2004

Mission Statement of the National Council

The Council exists to promote and develop the professional role of nurses and midwives in order to ensure the delivery of quality nursing and midwifery care to patients/clients in a changing healthcare environment.

Published by
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Foreword

The National Council for the Professional Development of Nursing and Midwifery (National Council) is pleased to present this report which evaluates the effectiveness of the role of the clinical nurse/midwife specialist (CNS/CMS).

As part of the National Council's ongoing function of monitoring the development of nursing and midwifery specialities, the research demonstrates that the introduction of the role of clinical nurse/midwife specialist in Ireland has been successful. From directors of nursing and midwifery through to staff nurses and midwives working on the front line - and also from the patients/clients receiving CNS/CMS care - there is unanimous agreement that the role is of huge benefit.

The study makes recommendations regarding role development, continuing professional development, development of posts and annual reviews of posts on a local, regional and national basis.

As the structures of the health services develop, the manner in which healthcare is delivered will continue to evolve. Changes in legislation as well as policy developments will continue to have an effect on the way that nursing and midwifery are practiced.

The National Council wishes to acknowledge the enthusiastic help of all those involved in the focus groups, the nursing and midwifery planning and development units (NMPDUs), directors of nursing and midwifery, CNSs/CMSs, staff nurses and midwives and patients/clients and all those who gave of their most precious commodity - time. Without the quality contributions of all those involved, it would not have been possible to complete this study.

In addition, I wish to record thanks to my colleagues, Kathleen Mac Lellan, Head of Professional Development; and Professional Development Officers, Christine Hughes, Mary Farrelly, Georgina Farren; Research Development Officer, Sarah Condell. Particular thanks are extended to Jenny Hogan, Professional Development Officer, for leading the research and for her commitment in the preparation of this report.

Yvonne O'Shea
Chief Executive Officer

Executive summary

This report benchmarks the progress of clinical specialism in nursing and midwifery in Ireland to the present time. Ireland is at an early stage of development of these roles within a formalised framework as set out by the *Report of The Commission on Nursing* (Government of Ireland 1998). The cohorts of CNSs/CMSs in post have clearly embraced the core concepts of the role and have been empowered to improve the quality of care for patients/clients: there is overwhelming support for the effectiveness of the role of the CNS/CMS.

It is clear that there is great potential for the role to develop in its responsiveness to service need. This report outlines critical areas for progress and describes a process for future development of roles at local, regional and national levels.

The international experience of clinical specialism in nursing/midwifery shows a continuum of development from the 1970s to the early 1990s. The role has developed from a 'bedding down' phase of role ambiguity, acceptance of the role and role clarification. Thereafter the movement has been in the direction of role evaluation, value for money, performance outcomes and the transition to advanced nurse/midwife practitioner (ANP/AMP). This continuum is reflected in the Irish experience as is evidenced in the data collected for this research. The National Council has issued clear and unambiguous guidelines in regard to role definition and educational preparation, which provide a robust foundation upon which to build the capacity of nursing and midwifery specialist posts.

As healthcare and social care services develop so too does the scope of practice of specialist roles. Continual re-evaluation of the progress and appropriateness of specialist nurse/midwife roles should be part of every healthcare organisation's service plan. Support should be provided in this re-evaluation process at regional level by the NMPDUs and at national level by the National Council. Increased specialisation may be seen as a positive element that will enhance the already important position of nursing and midwifery in the delivery of quality healthcare in Ireland.

Nursing and midwifery specialisms will support the implementation of national health policy, in particular the national health strategy *Quality and Fairness: A Health System for You* (2001a), *Primary Care: A New Direction* (2001b), *Audit of Structures and Functions in the Health System* (2003b) and the *Report of the National Task Force on Medical Staffing* (2003a). The CNS/CMS role has been able to respond to service demands in a flexible and innovative manner: examples of this are the establishment of nurse/midwife-led clinics and the development of specialist posts across services at regional level. There is great potential within these specialist roles to assist the integration of primary and secondary care.

The clinical aspect of the role is perceived as very important. It has been generally acknowledged that extensive clinical experience has helped to develop the role. The educational component of the role, however, requires further development; where development has taken place it is seen as being of benefit to staff nurses/midwives and to patients/clients. This finding would concur with Aiken's (2003) study which concluded that in hospitals with greater proportions of nurses educated at the baccalaureate level or higher, surgical patients experienced lower mortality and lower "failure to rescue" rates. Patients/clients agreed that the CNS/CMS was of great value to the quality of the care they received. CNSs/CMSs have an important role within healthcare settings in the provision of specialist knowledge and skills; however, they need ongoing support from their managers and medical colleagues and opportunities to participate in continuing professional development.

It is important for the integration of the CNS/CMS role that the postholders create strong working relationships with clinical managers, staff nurses and staff midwives. These relationships should be supported by ongoing feedback from line managers.

In order to ensure the sustained development of CNS/CMS roles in response to service need, there must be planned and co-ordinated review at local, regional and national levels. This should be closely linked with the service planning process. The report makes recommendations for role, education and service development at local, regional and national level.

Glossary

ABA	An Bord Altranais
A & E	Accident and Emergency
ADoN	Assistant Director of Nursing
ADoM	Assiatant Director of Midwifery
ANP	Advanced Nurse Practitioner
AMP	Advanced Midwife Practitioner
CMM	Clinical Midwife Manager
CMS	Clinical Midwife Specialist
CNM	Clinical Nurse Manager
CNS	Clinical Nurse Specialist
CPD	Continuing Professional Development
CSO	Central Statistics Office
DoH	Department of Health
DoHC	Department of Health and Children
DoN	Director of Nursing
DoM	Director of Midwifery
ERHA	Eastern Regional Health Authority
GP	General Practitioner
HIPE	Hospital In-Patient Enquiry
ICN	International Council of Nurses
ID	Intellectual Disability
ITU	Intensive Therapy Unit
MHB	Midland Health Board
MWHB	Mid-Western Health Board
National Council	National Council for the Professional Development of Nursing and Midwifery
NMC	The Nursing and Midwifery Council
NEHB	North Eastern Health Board
NMPDU	Nursing and Midwifery Planning and Development Unit
NWHB	North Western Health Board
OHM	Office for Health Management
RCN	Royal College of Nursing (London)
SEHB	South Eastern Health Board
SHB	Southern Health Board
UK	United Kingdom
UKCC	The United Kingdom Central Council for Nursing and Midwifery and Health Visiting
USA	United States of America
WHB	Western Health Board

Introduction

One of the main functions of the National Council as determined by *The Report of the Commission on Nursing* is to bring about a coherent approach to the progression of specialisation and the development of career pathways for nurses and midwives and to monitor the ongoing development of nursing and midwifery specialities, taking into account changes in practice and service need (Government of Ireland 1998).

The following statutory functions pertaining to the clinical nurse/midwife specialist are vested in the National Council.

- To monitor the ongoing development of nursing and midwifery specialities, taking into account changes in practice and service need.
- To determine the appropriate level of qualification for entry into specialist nursing and midwifery practice.
- To formulate guidelines for the assistance of health boards and other relevant bodies in the creation of specialist nursing and midwifery posts.

The National Council has undertaken this extensive research study to evaluate the effectiveness of the role of the clinical nurse/midwife specialist.

Aims and objectives

The aim of the research is to evaluate the effectiveness of the role of the clinical nurse/midwife specialist. The objectives are

- to examine the literature pertaining to the role and evaluation of the clinical nurse/midwife specialist
- to establish the parameters of the current scope of practice of the clinical nurse/midwife specialist
- to examine how the clinical nurse/midwife specialist enhances/supports the role of other nurses/midwives
- to review and appraise the National Council's job description guidelines
- to benchmark the current status in relation to role evaluation and the use of audit, taking into account that the role is at an evolutionary stage
- to determine the geographical and speciality spread across Ireland using the National Council's database
- to examine the use of the nomenclatures recommended by *The Report of the Commission on Nursing*
- to examine the titles of clinical nurse/midwife specialists and to agree a uniformity of titles where possible
- to make recommendations based on the findings regarding the future development of the CNS/CMS role.

Structure of the report

The report comprises five chapters.

- Chapter 1 provides an overview of the methodology adopted for the research.
- Chapter 2 reviews the development of specialist roles of CNS/CMS in Ireland and places the emergence of the role within the policy context.
- Chapter 3 contains a review of the literature and looks at the emergence of the role internationally.
- Chapter 4 presents the research findings.
- Chapter 5 sets out the conclusions, future developments and the recommendations.

CHAPTER 1

‘Our job is to empower, not to take away from other staff’

(CNS/CMS)

Methodology

1 Methodology

A mixed methodology approach was adopted. This consisted of an extensive literature review, focus groups, analysis of the National Council's CNS/CMS database and a questionnaire. The literature review examined relevant issues both in Ireland and internationally. The focus groups were held with clinical nurse/midwife specialists, directors of nursing and midwifery, clinical nursing and midwifery managers, staff nurses, staff midwives and service users. The questionnaire was sent to all clinical nurse/midwife specialists in an attempt to benchmark the role and examine issues that arose from the literature review and the focus groups. The National Council's CNS/CMS database was analysed from a geographical and distribution perspective.

1.1 Questionnaire

Methodology

The questionnaire was designed by adapting the Bamford and Gibson tool which examined the CNS/CMS role from differing perspectives (Bamford & Gibson 2000). Themes emerging from early content analysis of the first six focus groups were pursued in the questionnaire. Finally, the literature review elicited recurrent themes and these were further explored in the questionnaire.

Sample

The questionnaire was piloted with forty-seven CNSs/CMSs selected randomly from the National Council database. Participants were asked to comment on the format and content and adjustments were made accordingly. Following the pilot the questionnaire was sent to all 1,487 CNSs/CMSs on the database excluding those involved in the pilot. The response rate was 61% (n=808). Figure 1 shows the care setting in which the respondents work and Figure 2 represents the percentage of respondents from each division of the register. Care of the older person, palliative care, occupational health and general practice are all recorded under the general division of the register. Each division of the register had almost a 50% response rate. Figure 3 shows the respondents' specialist areas of practice.

Figure 1:
care setting of questionnaire respondents (n= 808)

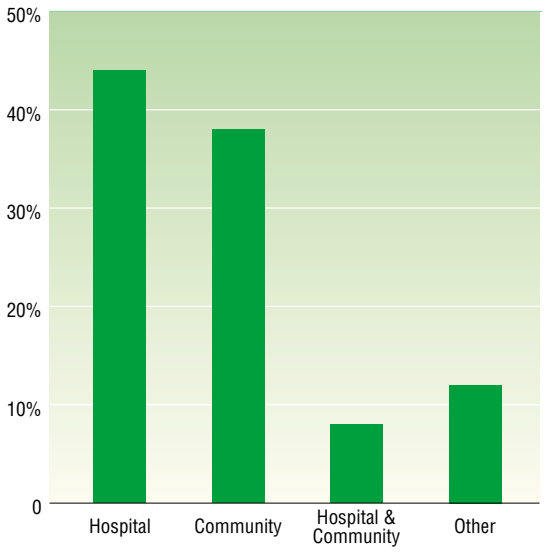


Figure 2:
response rate according to division of register (n=808)

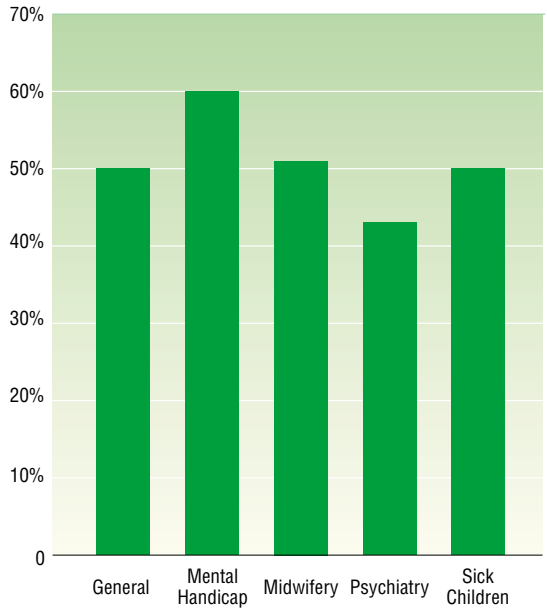


Figure3:
response by specialist area (n= 808)

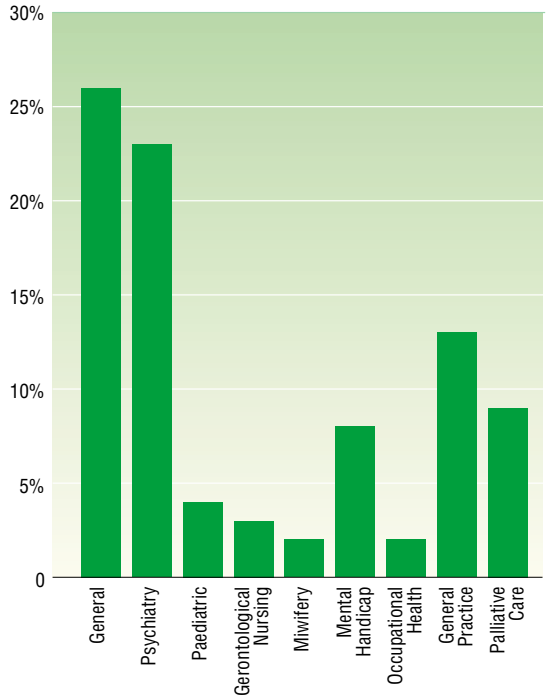


Figure 4 shows the mean age of the respondents. The majority were aged between thirty-five and forty-nine, and 87% were female.

Figure 4:
mean age of respondents (n=808)

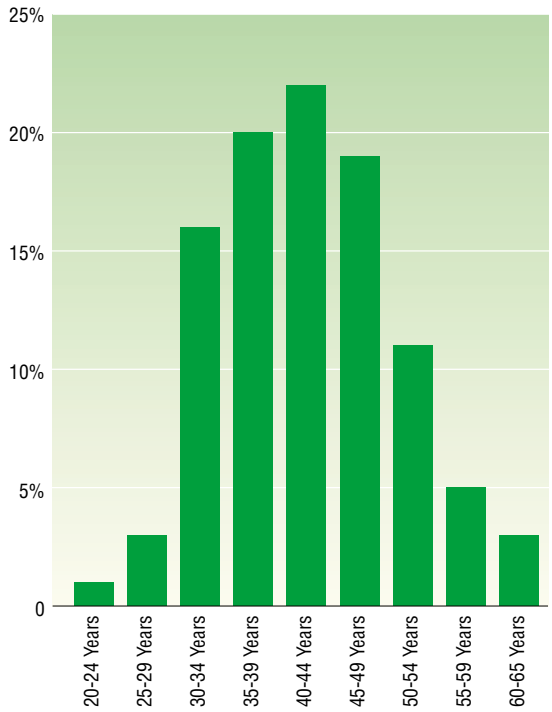
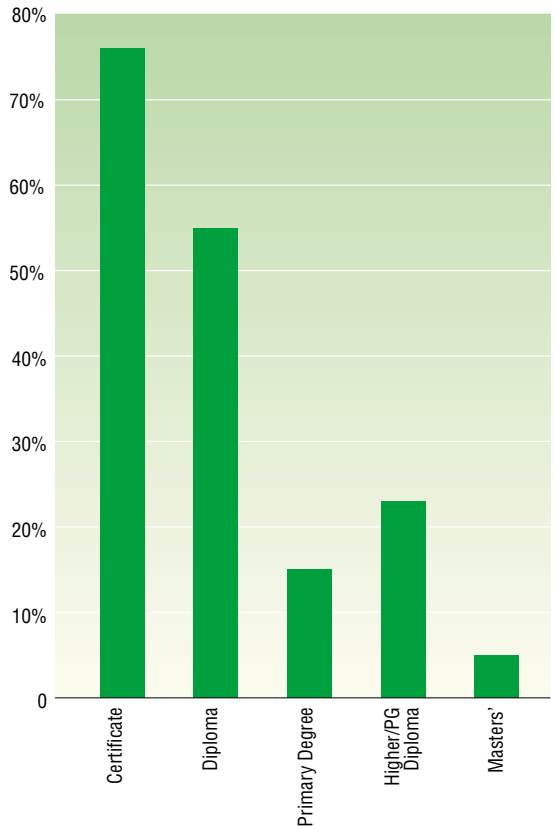


Figure 5 illustrates the educational status of respondents. The majority (77%) had certificates, 54% had diplomas, 15% had primary degrees, 23% had higher/postgraduate diplomas, and 5% had masters' degrees.

Figure 5:
educational preparation of respondents



1.2 Focus groups

Methodology

The use of focus groups as a method of data collection has now become firmly rooted in nursing research (Parahoo 1997). Asbury (1995) states that focus groups 'capitalise on the interaction within a group to elicit rich experiential data'. Krueger (1994) defines a 'focus group' as a carefully planned discussion, designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. The key feature of the focus group is the active encouragement of interaction among participants. The aim is not necessarily to achieve a universal consensus on a given topic but to produce qualitative data that provides insight into the attitudes, perceptions and opinions of the participants.

Focus groups were established to explore issues pertaining to the CNS/CMS role. Clinical nurse/midwife specialists, staff nurse/midwives, directors of nursing/midwifery, clinical managers and patients/clients were targeted. The nursing and midwifery planning and developments units (NMPDUs) took responsibility for planning and organising the focus groups.

The Office for Health Management (OHM) affirms that patients/clients have a right to play a more active role in defining and assessing quality, and they are increasingly demanding the opportunity to do so (OHM 2002). The OHM goes on to declare that the focus group methodology allows for the exchange and probing of ideas and facilitates a high level of flexibility in terms of discussion. Bearing this in mind it was decided to hold a single focus group comprising a selection of patients/clients, all of whom had received care from a CNS/CMS.

Recording and analysing the data from the focus groups

Guidelines were drawn up and each focus group was asked a similar set of questions. In order to achieve as much interaction as possible, the facilitators were provided with a training session to ensure a consistency of approach and were instructed to explore key themes in more depth as they emerged. At the end of each focus group session the scribe summarised her notes and read them aloud to the participants, allowing them to confirm, reinforce or contradict what had been discussed, thus ensuring a high level of face validity (Krueger 1994).

The researcher avoided making comparisons across different focus group sessions, choosing instead to examine broad themes, as suggested by Carey and Smith (1994).

Procedure

The questions devised for the focus groups were based on the study by Bamford and Gibson on the role and development of the clinical nurse specialist (1998, 1999a,1999b,1999c, 1999d, 2000). This study explored the role of the clinical nurse specialist using focus groups. Each set of questions in the Bamford and Gibson study was peer reviewed and tested in a pilot and all the findings from the live focus group were tested by two further focus groups. The data was deemed by the researchers to be reliable and the study

has been widely published. Thus the focus groups for this research were conducted with a high degree of validity and reliability. Appendix 2 contains the list of focus group questions for this study.

Sample

Eighteen focus groups with nurses and midvives were held across the country, and each health board was represented. Table 1 gives a breakdown of where each focus group was held and with which grade of staff. Parahoo (1997) suggests that the purpose for which the sample is recruited should determine the number of participants to be recruited; to that end fifteen to twenty-five participants were invited as it was considered that this figure would maximise representation from all divisions of the register and across all care settings, and would also allow for non-attendance on the day. The attendance at each focus group ranged from a minimum of eight to a maximum of twenty-four. Once the initial content analysis was completed, a final focus group was held to validate the themes that emerged.

Table 1:
breakdown of focus groups by health board

Health Board	CNS/CMS	Staff Nurses/ Midwives	CNM/CMM	DoN/DoM
ERHA	15			12
MWHB	15		11	
MHB	23	9		8
SHB	19		18	
SEHB	18	20		12
NEHB	12		9	
WHB	10	14		
NWHB	16			10
Total No. of Focus Group Participants	**128**	**43**	**38**	**42**

1.3 The literature review

The review examined the literature from the 1950s up to the present day. The search uncovered a huge volume of literature, the vast majority of which related to North America. The review included the United States of America, the United Kingdom, Hong Kong, Australia and Ireland. A content analysis approach was adopted; themes such as role development, role ambiguity, deskilling and role preparation appeared frequently in the early literature and themes such as outcome performance measurement, audit and research began to emerge in the latter years.

CHAPTER 2

‘The clinical nurse specialist humanised my experience of cancer’

(Patient)

The development of specialist roles in Ireland

2 The development of specialist roles in Ireland

2.1 The policy context

Various policy documents and strategies have influenced the development of nursing and midwifery specialities in Ireland. The *Report of the Commission on Nursing: A Blueprint for the Future* (1998) has been highly influential in the development of these specialities. Prior to that *The Working Party on General Nursing Report* (DoH 1980) recommended the appointment of specialist nurses who would enhance the quality of nursing care and provide specialist nursing advice to other nurses. The evolution of the roots of specialism in Ireland can be traced to that report (Condell 1998).

The national health strategy document *Quality and Fairness: A Health System for You* (DoH 2001a) recommends the development of further clinical specialist posts in nursing and midwifery within the framework of the National Council.

The *Report of the National Task Force on Medical Staffing* (DoHC 2003a) recommends that, in line with the philosophy of the *Report on the Commission on Nursing,* the scope for enhancing the role of nurses and midwives should be explored in detail with a view to identifying how such enhancement could be implemented nationally. The report states that there is considerable potential for nurses and midwives to enhance further the development of quality patient/client care and positive patient/client outcomes. The report confirms that the CNS/CMS role is already well identified and that it is in keeping with the Task Force goal of utilising the skills of health professionals.

Prior to the publication of the above report *The Report of the Forum on Medical Manpower* (2001) stated that the creation of clinical nurse/midwife specialist posts, and other developments such as the increased use of healthcare assistants, will have a significant impact on work practices in Irish hospitals. The report recommended that all concerned work together to develop services that will enhance the quality of patient/client care.

The Nursing and Midwifery Resource: Final Report of the Steering Group – Towards Workforce Planning (DoHC 2002c) recommends that the National Council monitor and evaluate the introduction of clinical nurse/midwife specialists throughout the health system in collaboration with the NMPDUs, directors of nursing and midwifery and service providers.

The Scope of Nursing and Midwifery Practice Framework (ABA 2000) has facilitated a new and empowering phase in Irish nursing. The framework was developed following consideration of national and international developments in nursing practice. Its aim is to support nurses and midwives in their determination, review and expansion of their scope of practice. The scope of practice is defined as 'the range of roles, functions, responsibilities and activities which a registered nurse is educated, competent and has authority to perform'. The document acknowledged the evolving roles of nurses and midwives and differentiated between the terms expansion and extension in favour of the former. It highlighted the principles and values that should underpin role development and expansion. It is a pivotal document around which nurses and midwives in Ireland for the first time have the facility at national level to develop their role within an agreed framework.

Audit of Structures and Functions in the Health System (DoHC 2003b) recommends the enhancement of system capability and performance. It recommends the continued advancement of the personal development planning process, which is established in some health agencies but not in all. It also recommends that the human resource division of the Health Service Executive (HSE) conduct an audit of the critical skills and competencies required in delivering system capability and performance.

Nurses' and Midwives' Understanding and Experiences of Empowerment in Ireland (DoHC 2003c) highlights the fact that empowerment can become a key requirement in encouraging the innovative practice that will underpin healthcare provision. It states that the challenge facing senior management is to harness the positive attitudes and skills of nurses and midwives in providing the direction necessary for the effective implementation of the health strategy. The factors adjudged to enhance empowerment include education, skills, knowledge and self-confidence. The factors identified as inhibiting empowerment are poor management style, lack of education, lack of support from management and lack of recognition from management and other professionals.

2.2 The National Council for the Professional Development of Nursing and Midwifery

There has been an unprecedented development of specialism in nursing and midwifery in Ireland over the last decade, and the range of titles and diversity of roles testify that this has come about in a flexible and innovative way in response to service need and patient/client need.

Most of the body of knowledge concerning the CNS/CMS functions in Ireland, prior to the establishment of the National Council, related to the clinical and educational fuctions, with little or no mention of the research role and no reference to the structure, processes or outcome measurements (Ruddy 1985, Cunningham 1993, Boland 1995, Redmond 1997, Shanahan 1997 and Meagan 1998).

The definition of clinical nurse/midwife specialist as outlined by the National Council is as follows:

> A nurse or midwife specialist in clinical practice has undertaken formal recognised post-registration education relevant to his/her area of specialist practice at higher diploma level. Such formal education is underpinned by extensive experience and clinical expertise in the relevant specialist area.
>
> The area of speciality 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 nursing research and audit and act as a consultant in education and clinical practice to nursing/midwifery colleagues and the wider multidisciplinary team (National Council 2001).

The five core concepts inherent in the role of clinical nurse/midwife specialist as determined by the National Government Council are the following.

Clinical focus

The role of the CNS/CMS must have a strong patient/client focus whereby the speciality defines itself as nursing or midwifery and subscribes to the overall purpose, functions and ethical standards of nursing (International Council of Nurses 1992). The clinical practice role may be divided into two categories, direct and indirect care (Markham 1988, Kersley 1992). Direct care comprises the assessment, planning, delivery and evaluation of care to patients/clients and their families. Indirect care relates to activities that influence others in their provision of direct care.

Patient advocate

The CNS/CMS role involves communication, negotiation and representation of the patient/client values and decisions in collaboration with other professionals and community resource providers.

Education and training

The CNS/CMS remit for education and training consists of both structured and impromptu educational opportunities to facilitate staff development and patient/client education (McCaffrey Boyle 1996). Each CNS/CMS is responsible for his/her continuing education through formal and informal educational opportunities, thereby ensuring sustained clinical credibility among nursing/midwifery, medical and paramedical colleagues.

Audit and research

Audit of current nursing practice and evaluation of improvements in the quality of patient/client care are essential. 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.

Consultant

Inter and intradisciplinary consultations, both internal and external, are recognised as among the functions contributed by the clinical nurse/midwife specialist to the promotion of improved patient/client management.

2.3 Immediate, intermediate and future pathways

In recognition of those nurses and midwives already functioning as CNSs/CMSs an 'immediate career pathway' for confirming them in CNS/CMS posts was developed by the National Council. The closing date for applications relating to this pathway was 30 April 2001.

The intermediate career pathway came into effect on 1 May 2001 and is the process by which all CNS/CMS posts are currently developed and approved (National Council 2001). All CNS/CMS applicants must enter a contractual agreement to pursue a higher/postgraduate diploma in a relevant subject area unless they have already done so.

The vision expressed in the *Report of the Commission on Nursing* (Government of Ireland 1998) was that in the future all CNS/CMS applicants must have undertaken a higher/postgraduate diploma prior to appointment as a CNS/CMS. It is timely that the National Council is currently undertaking an audit of the numbers and status of those currently approved under the intermediate pathway that have entered a contract to undertake a higher/postgraduate diploma. This audit, in conjunction with a review of the number of higher/postgraduate diploma programmes developed by the third-level providers, should inform the National Council as to when the future pathway can be invoked.

2.4 The nomenclatures

The *Report of the Commission on Nursing* (1998) recommended that the clinical career pathway and educational programmes applicable to CNSs/CMSs should be organised around seven broad bands of nursing and midwifery. The broad bands described by the Commission are

1) high dependency nursing (which might include areas such as coronary care, intensive therapy (psychiatry) and neonatal intensive care nursing)

2) rehabilitation and habilitation nursing (which might include areas such as care of the older person, spinal injuries and palliative care nursing)

3) medical/surgical nursing (which might include areas such as oncology, infection control, stoma care, neurosciences and anaesthesia nursing)

4) maternal and child health nursing (which might include areas such as parent craft, ultrasonography, paediatric cardiology and paediatric oncology nursing)

5) community health nursing (which might include areas such as health education and health promotion, family development and community psychiatry)

6) mental health nursing (which might include areas such as addiction counselling and behaviour therapy)

7) disability nursing (which might include areas such as sensory stimulation and challenging behaviour).

An analysis of these proposed sub-speciality titles has highlighted areas of possible overlap in specialist areas particularly in psychiatry and child health, for example, child psychiatry. These bands were not intended by the *Report of the Commission of Nursing* to replace or supplement the existing disciplines of nursing/midwifery which currently lead to registration. The intention was to give coherence and order to the multiple sub-specialist areas that have developed within each discipline. Since the *Report of the Commission on Nursing*, Ireland has witnessed a proliferation of titles. Appendix 3 demonstrates that there are currently 236 different titles in existence; these do not always reflect the domain of practice. It must be stressed that the diverse titles and domains have emerged in response to service need and it reflects the innovation and flexibility with which CNSs/CMSs and their organisations have developed the role. It is evident that new titles will continue to emerge as the CNS/CMS pathway develops and new domains of practice emerge.

In order to judge the feasibility of the organisation of the clinical career pathway around the broad bands it must be assessed whether the corresponding education provision for the clinical specialist post can be provided by the third levels around the broad bands. At the behest of the National Council each third level will be reviewing its current and future education programmes preparing nurses and midwives to be clinical specialists relative to the broad bands. This will then inform the National Council's consideration of the broad bands in relation to the clinical career pathway.

Educational requirements

The *Report of the Commission of Nursing* was of the view that the seven broad band categories should allow for greater flexibility when future career plans are being considered. It envisaged that the educational requirements for CNS/CMS would include common modules in the broad band area, together with sub-speciality modules. The vision outlined by the *Report of the Commission of Nursing* was one of great flexibility within educational establishments. Nurses and midwives working in very focused sub-specialist areas were to have the option of moving to related sub-specialist areas within their particular grouping. If the nurse or midwife then wished to move to another sub-specialist area, he or she could do so by simply completing extra modules of education. To date, this development has progressed, albeit slowly, and modular frameworks are emerging.

The National Council published *Guidelines on the Development of Courses Preparing Nurses and Midwives as Clinical Nurse/Midwife Specialists and Advanced Nurse/Midwife Practitioners* in 2002. The guidelines recommend that educational programmes should be developed in response to service need and that all key stakeholders should be engaged in the development and design of the programmes. These developments should be modular in design and processes for accreditation for prior learning should be devised.

2.5 Geographical distribution

The establishment of a database of CNSs/CMSs by the National Council facilitates examination of the geographical distribution of CNS/CMS roles. Table 2 demonstrates the number of CNS/CMS per head of population per health board. The national average of CNS/CMS per head of population per health board is one per 2,584.

Table 2:
*number of CNS/CMS per head of population per health board**
Source: National Council CNS/CMS Database Jan 2004

Health Board	Nos of CNS/ CMS	Population per Health Board	CNS/CMS per head of Population
ERHA	569	1,401,314	2,463
MHB	67	225,588	3,366
MWHB	135	339,930	2,518
NEHB	140	344,926	2,464
NWHB	111	221,376	1,994
SEHB	134	423,540	3,160
SHB	221	580,605	2,627
WHB	139	380,057	2,734
Total	**1,516**	**3,917,336**	**Av. = 2,584**

*Population figures based on Central Statistics Office estimated figures 2002 (*Health Statistics* 2002).

While geographical distribution provides a useful overview of the spread of clinical specialist roles, local service need will always dictate the necessity of establishment of posts. However, the database is a valuable tool for highlighting service need at local and regional level. For example, the majority of CNS posts in paediatrics are based in the ERHA region. While these provide outreach services to the rest of the country the question needs to be asked at a local and regional level whether parents and children require local access to specialist services. Table 3 illustrates this.

Table 3:
geographical spread of CNSs/CMSs by health board. It should be noted, that some CNS/CMS posts in general hospitals which provide service to paediatrics etc., are classified under general.
Source: National Council CNS/CMS Database Jan 2004

Health Board	General	Mental Handicap	Midwifery	Psychiatry	Sick Children	Total
ERHA East Coast	79	-	5	28	-	112
ERHA Northern	96	20	11	69	24	220
ERHA S/western	132	18	5	45	37	237
MWHB	79	14	3	38	1	135
MHB	37	3	1	26	-	67
NEHB	77	8	3	51	-	140
NWHB	64	6	1	39	1	111
SEHB	92	3	1	38	-	134
SHB	161	27	-	32	1	221
WHB	76	9	4	49	1	139
Total	**879**	**105**	**33**	**406**	**64**	**1,516**

Table 4 illustrates the development of posts by division of the register before and after the introduction of the intermediate pathway.

Table 4:
clinical nurse/midwife specialist – immediate and intermediate pathway
Source: National Council CNS/CMS Database Jan 2004

Division of the register	Immediate pathway	Intermediate pathway	Numbers approved
General	789	106	895
Mental handicap	100	8	108
Midwifery	28	6	34
Psychiatry	382	31	413
Sick children	60	6	66
Total	**1,359**	**157**	**1,516**

The database information with regard to division of the register and the health board is updated monthly and is available on the National Council's web site ***www.ncnm.ie***. This is the first time such detailed information with regard to clinical specialists in Ireland has been made available. This data should be used to inform the future developments of clinical nurse/midwife specialists. The database is a critical tool when planning the specialist nursing and midwifery workforce of the future.

2.6 The role resource pack

The recent publication and launch of the Role Resource Pack for CNSs/CMSs by the SEHB (funded by the National Council) is a welcome development. The pack aims to support and enhance the professional role of every CNS/CMS no matter where they are situated on the developmental continuum. It will assist CNSs/CMSs and their line managers to reflect and examine their role by using the five core concepts as a framework for role clarification, education and development.

The pack will help CNSs/CMSs with their line managers to formulate and implement a strategic plan for ongoing personal development. It will enable each CNS/CMS to demonstrate and highlight the unique and important contribution to patient/client care which is available through audit and evaluation and it will assist the CNS/CMS to establish clear communication both on an interdisciplinary and intradisciplinary basis.

Finally it will help the CNS/CMS and the line manager to support bids for extra resources and ultimately to publicise the role of the CNS/CMS through report writing – in particular an annual report. The pack's content reflects the issues raised in the literature and identified in the focus groups, and is an extremely pragmatic and useful tool for all CNSs/CMSs. The pack is available on the National Council's website ***www.ncnm.ie.*** The pack will be discussed further in Chapter 4.12.

CHAPTER 3

‘If they help the patient then they help us to do our own work’

(Staff Nurses/Midwives)

The international experience

3 The international experience

3.1 Introduction

The themes identified in the literature both nationally and internationally, which are covered in this chapter, include early role development and preparation, the diversity of titles used to describe the CNS/CMS, the issue of deskilling, outcome performance measurement and role progression. The development of the role in the United States of America, the United Kingdom, Hong Kong and Australia is examined.

The literature is replete with references to role definition, role clarity, role models, role conflict, role performance, ambiguity regarding the role, role evolution, implementation of the role and, ultimately, role integration (Appel 1996, Bousfield 1997, Chang 2001, Gibson 2001 & McCreaddie 2001, Castledine 2002). The last thirty years have seen the introduction of the clinical nurse/midwife specialist worldwide, at the same time as advances in technology have revolutionised the way nursing and midwifery and medical care is delivered. It is inevitable that there has been debate and discussion regarding the role.

There is a wealth of literature claiming that the role of the CNS/CMS is poorly understood and, as a result, is often underutilised or used in an inappropriate manner (Loudermilk 1990, Appel 1996, Armstrong 1999, McGee 1999 & Chang 2001).

Australian studies suggest that CNSs/CMSs have been vague about their role (Duffield et al 1995). Similar studies in America (McFadden and Miller 1994) found that CNSs/CMSs expressed the need for definition and clarification of their role. This lack of role clarity may be due in part to the constant evolution and developing nature of the role, bearing in mind the necessity to keep up to date with technological developments and changing healthcare settings (Breeze 1995). Some CNSs/CMSs are reported to consider this lack of role clarity as beneficial in that it confers a certain amount of flexibility on the role (McFadden and Miller 1994). Nash (1993) goes so far as to suggest that this ambiguity and lack of clarity may be what allows specialist nurses to be innovative.

Although healthcare systems differ from continent to continent, the issues related to role definition traverse international boundaries. According to Duffield (1995) the role cannot be meaningfully evaluated until the functions are clearly delineated. It has been suggested by Armstrong (1999) that the role of the CNS/CMS varies. This is usually perceived in the literature as a criticism. However, it must be emphasised that each CNS/CMS interprets his or her role uniquely, depending on the care setting, the expectation from nursing and midwifery management, the needs of staff and patients/clients, and the goals of the individual CNS/CMS.

The ultimate aim of the CNS/CMS is the provision of high quality nursing care (Hodgman 1983, Webber 1993). Within the Irish context, and with this to the forefront of its thinking, the *Report of the Commission on Nursing* issued clear guidelines for the development of the role of the CNS/CMS. As a consequence the National Council has constructed a framework for the establishment of clinical nurse/midwife specialists in Ireland. This framework includes a definition of the role of the CNS/CMS and an outline of the five core concepts, which were published in the intermediate pathway document (National Council 2001). In addition the monitoring role of the National Council allows for on-going review of developments at a national level.

3.2 Early role development and preparation

In the early literature (Felder 1983) one of the commonly cited reasons for the introduction of CNSs/CMSs is that the positions arose in response to a lack of clinically skilled nurses at the bedside, this deficit having been caused by the movement of clinically skilled nurses into managerial positions. Later sources suggest that the posts were created in order to help reduce junior doctor working hours through the provision of medical assistants (Armstrong 1999). Clinical nurse/midwife specialists have had a variety of titles and this has led to some confusion and frustration over role differences and the identification of key competencies. The international experiences, particularly the Australian, influenced the recommendations of the *Report of the Commission on Nursing* in relation to the criteria and processes surrounding the CNS/CMS role and the linking of CNS/CMS status to posts in the service.

The following section briefly benchmarks the situation in the United States of America, the United Kingdom, Australia and Hong Kong.

The United States of America

Clinical nurse specialist roles were first formalised in the United States of America in the 1950s. They were introduced to prepare bedside nurses who would serve acutely ill patients via consultation and direct care (Cohen et al 2002). The clinical nurse specialists were to be expert clinicians, consultants, educators and researchers. The early clinical nurse/midwife specialists were ward or unit specific. According to the National Association of Clinical Nurse Specialists, all CNSs are educationally prepared to masters' degree or doctorate level. 'Advanced practice registered nurses' (APRNs) is an umbrella term used to describe nurse anaesthetists, nurse midwives, nurse practitioners and clinical nurse specialists –- they are all appropriately qualified nurses who assume primary responsibility for the direct care of clients. Morse and Brown (1999) report that difficulties are experienced between the CNS/CMS and the ANP/AMP roles. They suggest that each is competing for the other's client/patient load. This has led to calls in the United States for the two roles to be

merged, which may reflect the health funding processes.

The United Kingdom

The United Kingdom experience can be dated to 1943 when Frances Reiter first coined the phrase 'nurse clinician' (Bousfield 1997). The modern development began in the 1970s, following the introduction of the Salmon Report (Ministry of Health 1966). Many of the first nurse specialists had to rely on their own individual flair, inclination and innovation because role models were scarce (Castledine 2002). The UKCC (1994) regarded a CNS/CMS as a nurse who was able to demonstrate a level of knowledge, decision-making and skill in one particular aspect of nursing. According to Robb (2001) there is no clear agreement on the competencies expected of nurses/midwives using titles such as clinical nurse/midwife specialist. The UKCC adopted the term 'higher level practice' in preference to 'specialist' and 'advanced' nursing practice and the 'nurse consultant' role has also recently been introduced. This proliferation of titles may lead to considerable role confusion. The Nursing and Midwifery Council (NMC) has stated that there is no national agreement on the meaning of the title 'clinical nurse specialist'; it is merely an employment title (NMC 2003). The NMC has set the standard of education for CNSs/CMSs at not less than primary degree level and the programme must be made up of 50% theory and 50% practice. The NMC is currently considering the introduction of a register for specialist practice.

Australia

The CNS/CMS role was introduced in New South Wales in 1986 (Duffield 1996). The responsibility of managing the ward or unit was allocated to nursing unit managers, leaving the clinical expertise and clinical leadership to the CNS/CMS. The simultaneous introduction of the two roles resulted in confusion as to who was responsible for what. The CNS/CMS had some freedom in deciding the direction the role would take, as well as some responsibility for ensuring that roles were consistent with the professional aspiration of the position and that they provided a basis for future development (Appel 1996). Duffield et al (1995) in a study of 373 Australian clinical nurse/midwife specialists identified that the highest qualification attained was a graduate diploma –- 73% of CNSs/CMSs had attained a post-basic certificate provided by a hospital. *The Report of the West Australian Study of Nursing and Midwifery: New Vision, New Direction* (2001) gives a commitment to develop a credentialling framework for specialist and advanced practice nurses. However, there is no national statutory body responsible for regulating the development of the CNS/CMS. There is no standard approach to role development –- each health service develops its own individual job descriptions.

Hong Kong

The 'nurse specialist' role appeared in Hong Kong as late as 1994 when the Hospital Authority of Hong Kong introduced it into major hospitals (Chang 2001, Chuk 1997). Chang claims that the rationale for the introduction of the nurse specialists was to entice nurses to remain in clinical practice and to formally recognise the nursing contribution to clinical service.

The nurse specialist does not require registration with the Nursing Council; control of practice, as in the UK, is the remit of the employer. There are various types of degree and speciality courses, but nothing is uniformly prescribed by a higher authority as a pre-requisite to becoming a CNS/CMS.

3.3 Titles

The literature is full of ambiguity about the terms 'clinical nurse/midwife specialist' and 'advanced nurse/midwife practitioner', constantly using the two terms interchangeably (Fenton et al 1993, Castledine 1995, Bamford & Gibson 1998, Cox 2000). There is no universally accepted definition of the role of clinical nurse/midwife specialist and there are no agreed universal standards for educational preparation.

There is a diversity of titles for CNSs/CMSs, and this leads to confusion, ambiguity and ultimately resistance to the role itself. The titles often do not reflect the domain of practice. It is evident that titles and domains have grown in response to service need and they reflect the innovation and flexibility employed by nurses and midwives in adapting to an ever-changing healthcare system.

The role of the CNS/CMS has also had to respond to the changing healthcare environment. It is suggested that role ambiguity and differences in role expectations lead to difficulty when introducing and integrating the role (Loudermilk 1990). Bamford and Gibson (1998) claim that the current proliferation of unregulated titles adds to the confusion and ambiguity.

Discussion and agreement are necessary prerequisites to aid other healthcare professionals in understanding how the CNS/CMS role complements their own roles (Miller 1995, Redekopp 1997). An analysis of the diverse titles of roles in Ireland and internationally would suggest that these titles fall into a number of categories: Table 5 is representative of some of these categories.

Table 5:
categories of roles

Category	*Example*
Symptoms	lymphodema, dyspnoea, pain, deliberate self harm, eating disorders
Diseases	diabetes, multiple sclerosis, Parkinson's, AIDS, autism
Treatments	chemotherapy, radiotherapy, family therapy
Health promotion	health advice, health and well being, mental health promotion
Assessments	coloproctology, elderly assessment
Areas of care	stoma care, tracheostomy care, addiction

3.4 Deskilling

The issue of deskilling of other nurses/midwives by clinical nurse/midwife specialists occurs throughout the literature. Savage (1998) stated that the failure to recognise and acknowledge clinical nurse/midwife specialist skills and expertise may result in deskilling. Marshall (1999) discusses deskilling and suggests that part of the problem manifests itself as conflict. The CNS/CMS is perceived to act, or acts, as a judge of the care that ward staff are delivering. Marshall claims that when the specialist makes unilateral decisions about patient care, does not share her/his knowledge and is autocratic, conflict will inevitably arise and the 'generalist' nurse/midwife will abdicate care. Miller (1995) states that one of the CNS/CMS roles is to teach the generalists how to expand their own roles and improve patient/client care, not to take over that care.

Thus, it is imperative that CNSs/CMSs reduce these anxieties by overcoming the barriers and presenting the advantages of their roles. Marshall and Luffingham (1998) believe that with greater role definition, teaching and sharing of knowledge, generalist nurses/midwives will be encouraged to broaden their boundaries and hence reduce conflict.

Castledine (2000) stresses that it is the duty of all specialist nurses to seek to stop staff becoming deskilled. Castledine goes on to suggest that good communication, staff education and support to nursing staff should all help to prevent staff nurses from becoming deskilled. Wade and Moyer (1989) suggest that specialist nurses/midwives actually assist in increasing the knowledge of their generalist colleagues and that specialist care complements the care delivered by the generalist rather than replacing it. In a study of palliative care clinical nurse specialists, Jack et al (2002) concluded that it was senior nursing and medical staff who perceived junior staff were being deskilled. In their discussion, Jack et al suggest that because staff nurses may not be fully aware of the complexity of the CNS's role, they might make different assumptions about the exact role of the CNS. The solution to this, according to Marshall (1998), lies with the specialist nurse/midwife collaborating and demonstrating the efficacy of the contributions that she/he can bring to the clinical area without taking over care. Thus, effective change management and excellent interpersonal skills are paramount.

3.5 Outcome performance measurement

The national health strategy *Quality and Fairness: A Health System for You* (DoHC 2001a) states that quality assurance mechanisms will be introduced as a means of improving performance and preventing problems. This will be achieved via a structured set of planned and systematic activities such as documentation, training and review. This approach, according to the strategy will allow the quality of services to be benchmarked. Contemporary nursing literature is in tune with this position; it examines issues such as performance measurement, outcomes for patient/client care, value for money, peer review, regulation and the provision of role resource packs to aid the CNSs/CMSs in evaluating their own performance (Hammerton 1999, Humphris 1999, Bamford and Gibson 2000, McCreaddie 2001).

Outcomes are described as the end results of a treatment or an intervention or change in the health status of patients/clients as a result of the care they received (Oermann & Floyd 2002). Florence Nightingale first articulated the importance of evaluating outcomes of care when she documented morbidity and mortality rates during the Crimean War in an attempt to highlight the appalling standards of care (Urden 2001). Medical definitions of outcomes were originally known as the five 'Ds' –- death, disease, disability, discomfort and dissatisfaction. Urden would suggest that there are currently five different types of outcomes (see Table 6).

Table 6:
examples of outcomes measurement

Type of outcome	*Example*
Clinical outcomes	mortality, morbidity, infection, medical conditions, loss of function, physiological response, symptom control, constipation, nutritional status, sleep maintenance, low birth weight
Psycho-social outcomes	coping, stress management, return to work, role functioning, family functioning, anxiety, sexual functioning and knowledge
Functional outcomes	quality of life, self care, bathing, eating, dressing, mobility, communication, return to work or normal activity, symptom control
Fiscal outcomes	length of hospital stay, re-admission to service, A&E visits, healthcare services utilisation, cost per episode of care, resource utilisation
Satisfaction	consumer, care provided, services provided and the care provider, care and services provided to family

Humphris (1999) suggests that 'all professionals should measure in some way the impact of their skills and knowledge in relation to the needs of those for whom they provide a service' (p. 377). Most CNSs/CMSs need pragmatic, efficient strategies for incorporating the measurement of impact and outcomes into their daily practice. One of the most common deficits among nurses attempting to measure outcomes is the lack of rigorous baseline data collection (Prevost 2002). Baseline surveys of staff knowledge about specific clinical phenomena, such as pain management, are an extremely valuable and effective way of demonstrating the impact of CNS/CMS educational and clinical interventions.

Outcomes research is also complex in that it is difficult to attribute outcomes solely to the inputs of the nurse/midwife given the broad range of health professionals potentially involved in care. Spilsbury (2001) recommends that further research be targeted towards the impact of new roles on treatment and compliance, clinical outcomes and cost effectiveness, a

review of legal and accountability issues, and development of education and support. The economic benefits of the role of CNS/CMS are beginning to be addressed (Edwardson 1992, Bakker 1995); however this discussion is largely situated in the American context. Heasell (1996), writing from the UK perspective, suggests that advocates of nursing specialisation would be wise to demonstrate that they take evidence about cost effectiveness seriously when presenting their case for more resources.

Outcomes in critical care, for example, may be a function of chronic illness rather than unsuccessful intervention. Nursing responsibility in the critical care context addresses not only recovery but also the care of the dying and the support of relatives, the effects of which are difficult to measure. Ball (2001) urges the critical care nurse specialist to consider the following areas, which will have a positive impact on patient outcomes

- decreasing the incidence of complications associated with critical illness
- timely and appropriate admission to and transfer from critical care areas
- quality of life following critical illness
- continuity across the trajectory of care and
- enhanced coping mechanisms in the chronically ill.

This theme is detailed in a paper describing the benefits of follow-up outpatients' service developed by the clinical nurse specialist in critical care, which highlighted the CNS as a vital link between the intensive therapy unit and all outside agencies, extending into the community (Hall-Smith 1997).

Cowman et al (2001), in an examination of the role and function of psychiatric nurses in clinical practice in Ireland makes no mention of measuring outcome performance or auditing of numbers. The study concluded that while psychiatric nurses have been innovative and have initiated many new services, the main focus of their role related to caring interactions.

In their evaluation of the development of primary care walk-in centres, that were nurse-led*, Rosen and Mountford (2002) found that most of the nurses were enthused and motivated by the challenge of developing new skills and working as autonomous practitioners. The core activities led nurses to extend their traditional caring role into the diagnostic and curative domain. Further work is required to clarify the range of competencies needed to support this practice. Table 7 documents a sample of studies undertaken to explore performance outcome measurement.

Most of these studies are concerned with favourable patient/client outcomes rather than incorporating what patients/clients value. However, increasing consumer interest in healthcare is beginning to be recognised as important. Thus the positive value statements of patients regarding nurse-led practice and further developments in the methodologies exploring patients/clients' perceptions, alongside the outcomes of nursing interventions, will give performance measurement more credibility.

In exploring the contribution of nursing management to the development and support of new roles Wilson-Barnett (1998) identifies the possible conflicts arising from the advanced practice agenda. This agenda is described as ambitious but worthwhile and the authors recommend that nurse managers ensure that a comprehensive evaluation of the impact of the new roles is undertaken, not merely on cost effective healthcare but also on the impact on the nursing and multidisciplinary team. Wilson-Barnett strongly recommends that nurse mangers must demonstrate strong support for the nurse specialist and managers must be ready and willing to accept new ideas and change in a constructive manner.

Table 7:
studies exploring performance outcome measurement

Author	Target/method	Outcome	Change in practice
Garvican et al (1998)	Breast clinic – patient satisfaction	Improved patient satisfaction	Establishment of a nurse-led outpatient clinic
Hall-Smith et al (1997)	CNS-led intensive care unit	Consistency with previous research findings	Establishment of a follow-up CNS ICU clinic
Mackintosh and Bowles (1997)	Nurse-led acute pain service	Statistically significant changes in levels of pain	Further research, and continue implementing new service
Forster and Young (1996)	CNS visits to patients and carers with strokes	Improvement in social activities for mildly disabled patients	Increased visits from CNS to stroke patients and their carers
Hill (1994)	RCT rheumatology NP versus Consultant	Significant outcomes after forty-eight weeks	Nurse-led clinic introduced
Mallows et al (1990)	Nurse management of diabetes clinics	Specialist nurse clinic as effective as a doctor's clinic	Establishment of nurse-led diabetic clinics

*Nurse-led care is distinct from nurse co-ordinated or nurse-managed services. Nurse-led care is provided by nurses responsible for case management, which includes comprehensive patient/client assessment, developing, implementing and managing a plan of care, clinical leadership and decision to admit or discharge. Patients/clients will be referred to nurse-led services by nurses, midwives or other healthcare professionals, in accordance with collaboratively agreed protocols. Such care requires increased skills and knowledge and the nurse will need preparation in both the clinical and management aspects of the role. Such nurses will be practising at an advanced level and may be working in specialist or advanced practice roles (National Council 2003).

The literature is now beginning to explore the concept of a role resource pack to assist the CNS/CMS with audit and outcome performance measurement processes (Hammerton 1999, McCreaddie 2001). This demonstrates a tendency to move away from the themes of role clarity and ambiguity almost to the same extent as the literature of the 1980s and 1990s articulated the anxiety and uncertainty about the introduction of the role. It is evident that the CNS/CMS role has undergone its 'bedding down' phase and is now more established. Whether or not this is true in the Irish context is unclear due to the paucity of research.

3.6 Role progression

Any nurse or midwife who embarks on a new pathway or role will inevitably experience a period of role development before being able to function with maximum effectiveness (Hamric & Taylor 1989 cited in Bamford & Gibson 1999). The role transition can be challenging. For that reason it is imperative that structures are put in place to ensure that the introduction of the role has an optimal level of efficacy.

Progression from staff nurse/midwife to CNS/CMS and from CNS/CMS to ANP/AMP needs careful consideration. Guest et al (2001) stress the need for further research into the ways that nursing and midwifery roles evolve. This evolution needs to happen in tandem with assessment of the impact of the role on patient/client care and the contribution that the CNS/CMS makes to the delivery of care within modern healthcare. Roles can evolve as an outcome of an industrial dispute or as a solution to a problem that has not been primarily addressed. Wood (1998) suggests that nurses who are in transition to the ANP/AMP role tend to put their energy into gaining competence in clinical skills, as opposed to wider 'professional' skills, thereby allowing skills in audit, research and clinical supervision to remain underdeveloped.

As alluded to above there is some discussion in the literature that the future of the clinical nurse/midwife specialist lies in merging the role with the advanced nurse practitioner (Bussen & Engleman 1996, Wilson-Barnett & Beech 1994). This discussion is mainly confined to the American experience. Elder and Bullough (1990) note that the two roles overlap and that there is similar educational preparation for both.

In the Irish context it is the experience of the National Council to date that much preparatory work needs to be undertaken to avoid this overlap in the progress of CNS/CMS to ANP/AMP. The ANP/AMP candidate and the relevant organisation must go through a 'reforming' process that involves letting go of old functions in order to embrace new ones (National Council 2003).

3.7 Conclusion

The literature of the 1970s to the early 1990s shows that the CNS/CMS role was then in its 'bedding down' phase, making frequent reference to role development, role ambiguity, acceptance of the role and role clarification. As the 1990s moved on, so did the discussion, with issues of role confusion and acceptance being replaced with dialogue around role evaluation, value for money, performance outcomes and the transition to ANP/AMP.

Nursing and midwifery practice moves in tandem with medical and technological advances, health and social policy and demographic changes. The development of CNS/CMS positions, together with the concomitant recognition of increased skill and knowledge, has resulted in benefits for nurses, midwives and patients/clients. Yet many pressures, such as financial rectitude, increased patient/client acuity and the need to achieve customer satisfaction and quality care, are placed on all healthcare professionals. Within this healthcare setting, CNSs/CMSs have an important role in providing specialist knowledge and skills; but they need ongoing support from their managers and medical colleagues and they require real opportunities to participate in continuing professional development. Continual re-evaluation of the development and appropriateness of CNS/CMS roles ought to be part of every healthcare organisation's service plan. This will benefit nurses and midwives, the healthcare system and ultimately the patient/client.

CNSs/CMSs roles are evolving and will continue to do so as the demand for specialisation continues apace. Increased specialisation can be seen as a positive factor that will enhance the already important role that nursing and midwifery plays in the delivery of quality healthcare in this country. Ireland is uniquely placed within the context of the international experience. Internationally, there is still confusion about role definition and educational preparation. The National Council, however, has issued clear guidelines for role definition and educational preparation of CNSs/CMSs. In this regard it must be recognised that we have an extremely robust foundation, in Ireland, upon which to build.

CHAPTER 4

‘To provide evidence-based specialist care’

(Nurse/Midwife Manager)

The research findings

4 The research findings

The themes that emerged from the focus groups and from the questionnaire data are presented in this chapter. The themes include the essential functions of the role, role preparation, success of the role and barriers to role development. They are presented from the various perspectives, i.e., those of directors of nursing/midwifery, staff nurses/midwives, CNSs/CMSs and clinical nurse/midwife managers and patients/clients. There is some thematic overlap and some themes warrant more discussion than others. They are not presented in order of importance. Where appropriate, verbatim quotes are used to illustrate a point.

4.1 The key functions

In order to discover how members of the focus groups perceived how the CNS/CMS role functioned, each focus group was asked to identify the key functions of the CNS/CMS role. The findings below are presented by focus group.

The directors of nursing/midwifery perspective

The directors of nursing/midwifery were all in agreement that the CNS/CMS must be able to fulfil the requirements of the five core competencies. They suggested, however, that it is not always easy to identify if and how the CNS/CMS is achieving this. In order to facilitate the CNS/CMS to operate at the level of the five core concepts, the directors felt that continuing professional development was essential in areas such as networking, audit development and research utilisation. Clinical supervision and administrative support were seen as necessary for role fulfilment. It was felt that the CNS/CMS operates at the level outlined by the National Council.

Some directors were strongly of the view that the main thrust of the role must be on the clinical side; others said that education of staff, students and patients/clients was more important. Some believed that there was room for development of the educational component of the role, but in general there was agreement that the educational element was well utilised. This manifests itself in direct advice on care, providing evidence-based information, running local conferences, exchanging information, and updating on products.

Research and audit were considered by all the directors to be the least developed core concept.

'Audit and research – a bit more time is needed, not enough training.' (DoN/DoM)

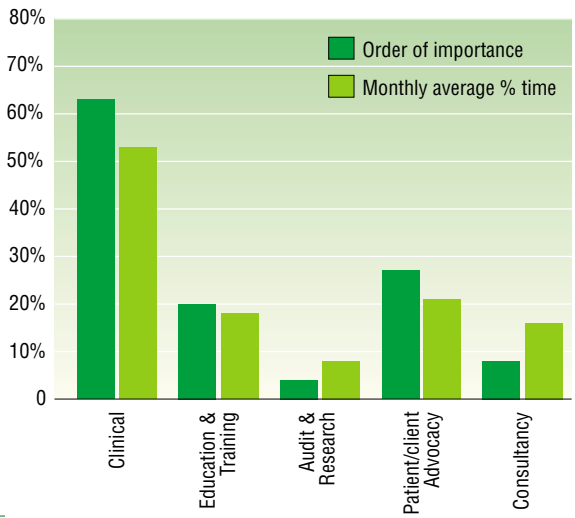
It was thought that sometimes, due to what was referred to as 'power play', the autonomous nature of the role was difficult to achieve. Overall, it was felt that there are differing levels at which individual CNSs/CMSs operate due to factors such as the care setting, the role, the level of clinical input and the focus of the post. There was general agreement that the role is in an evolutionary phase, and that different CNSs/CMSs are at different levels along the evolutionary continuum.

'Not quite getting there, only two years, should take another couple.' (DoN/DoM)

The clinical nurse/midwife specialist perspective

There was overwhelming agreement by CNSs/CMSs that the educational function was the most important component of their role. The clinical aspect was cited as the next most important key function, with the advocacy, consultancy, audit and research roles discussed less frequently. These findings, however, were not reflected in the data from the questionnaire. Question five asked respondents to score in order of importance how they rated the five core concepts. 63% rated the clinical aspect of the role as most important while only 20% rated education as the most important. This compared with 26% who felt the patient advocacy function was the most important. Only 4% of respondents to the questionnaire felt that the audit and research functions were the most important aspects of their role*. This is reflected in the monthly average time spent working on the requirements of the five core concepts: CNSs/CMSs spend 53% of their time on issues relating to clinical matters and 21% of their time on advocacy. This implies a strong correlation between how important the core concept is to CNSs/CMSs and how much time they devote to the requirements of that core concept (see Figure 6).

Figure 6:
percentage relationship between order of importance and average time spent on core concept



*Some respondents rated the clinical and educational aspects of the role equally.

Some CNSs/CMSs felt that it was quite difficult to articulate what the role was about because it is expanding all the time and because of its diversity.

'Very wide and diverse, the role is expanding, everyone looking for you, you are pulled in so many directions.' (CNS/CMS)

This difficulty was confirmed in the questionnaire responses. The CNSs/CMSs were asked to estimate the amount of time spent on various activities. The question is complex and many CNSs/CMSs commented that it was difficult to answer. However, what is apparent again is the consistency with which CNSs/CMSs engaged in direct clinical care - 57 hours *on average* per month were spent on direct clinical interventions with patients/clients, as opposed to only 4 hours on audit (see Table 8).

Education for CNSs/CMSs meant education of the patients/clients, their families/significant others, nursing and midwifery staff and students and other healthcare professionals.

'Education is important, our job is to empower, not to take away from other staff.' (CNS/CMS)

Most CNSs/CMSs were of the opinion that teaching patients/clients to be self-caring and to take control of their health/illness was the ultimate goal of their service.

Health promotion was seen as part of this education package and was viewed as a vital component of the role.

Planning individual care for patients/clients and planning for the service as a whole was identified as an important part of the role. Audit was highlighted as an evolving component of the role. Many members of the focus groups stated that there was not enough time to conduct audit. Some CNSs/CMSs already undertook quite sophisticated auditing and reporting of their work and were keen to rationalise its importance.

'Audit is important, I do a certain amount, but have no secretary to type it up.' (CNS/CMS)

'I'm doing it to improve the patient service and to see if we can improve their lives.' (CNS/CMS)

'Audit, only there three months, I'm developing a database.' (CNS/CMS)

'Going to audit our services, see how many patients we have, how many have been in hospital before, how many readmitted since the clinic started.' (CNS/CMS)

It is evident that the individual CNS/CMS determines the weight of focus of the five core concepts. This suggests that there is no standardised way for CNSs/CMSs to divide up their work –- this would appear to be dictated by service need and the needs of the individual patient/client and their significant others.

Some CNS/CMSs felt that it was difficult to get research onto the agenda.

'Hard to get research established; have to dig your heels in to get nursing research on the agenda.' (CNS/CMS)

Table 8:
average hours per month spent on itemised activities

Activities	Average hours
Direct clinical interventions with patients/clients	57
Nurse/midwife-led clinics*	27
Education and training of patients	25
Multidisciplinary clinics	18
Other	16
Travelling while at work	13
Report writing	12
Discussion with nurses/midwives regarding patient/client care	11
Clerical –-- making appointments, filing and retrieving notes	11
Discussion with multidisciplinary team regarding patient/client care	10
Education and training of student nurses/midwives	10
Telephone consultation with patients/clients	10
Education & training of registered nurses/midwives	9
Continuing professional development (formal courses)	8
Attending meetings	7
Telephone consultation with nurses/midwives	6
Telephone consultation with multidisciplinary team	6
Continuing professional development (informal, e.g. reflection, accessing library, clinical supervision etc)	6
Auditing/evaluating quality of patient/client care	5
Nursing/midwifery research	5
Education and training of multidisciplinary team	4
Auditing/evaluating own practice	5
Medical research (i.e. collecting data not used for nursing/midwifery purposes)	4

**Nurse/midwife-led clinics are defined as care provided by nurses or midwives responsible for case management which includes comprehensive patient/client assessment, clinical leadership and decision to discharge as appropriate.*

'I haven't established research in my area.' (CNS/CMS)

'Action research in midwifery has been implemented; a small project can make small changes in practice.' (CNS/CMS)

'Audit is being done, but education is needed to turn audit into research.' (CNS/CMS)

The staff nurse/midwife perspective

According to staff nurses/midwives the key function of the CNS/CMS was to be an educator and a resource for staff, students and patients/clients. This links to the perception of the role prevalent among CNSs/CMSs themselves.

'The CNS/CMS is a great crutch, primarily to the patient; they are in a position to impart information to make patients reassured.' (staff nurses/midwives)

CNSs/CMSs were regarded by the staff nurses and staff midwives as being specialists in their own areas due to having more in-depth knowledge and expertise. As was the case with CNSs/CMSs, the staff nurses/midwives thought that health promotion should play an important part in the CNS/CMS role. Some thought that the clinical focus component was the most obvious expression of the role, while others believed that some CNS/CMS posts were removed from the clinical area. There were conflicting ideas about the clinical function of the role.

'Clinical focus, yes, not removed from patients, very involved, very integrated.' (staff nurses/midwives)

There was a view that due to the nature of their posts some CNSs/CMSs could not possibly fulfil the requirements of all five core concepts. Other staff nurse/midwife groups suggested that CNSs/CMSs probably did not embrace the five core concepts because they did not have the time available to do so.

One staff nurse/midwife group felt strongly that CNSs/CMSs used the advocacy component of their role very effectively. It was felt that CNSs/CMSs were good at reaching the patient/client level.

'Patient information and support for the patient, a lot of securing for the patient.' (staff nurses/midwives)

Some staff nurses/midwives were not sure if CNSs/CMSs audited their work. Those that felt sure they did, were not involved, nor did they receive any feedback from audit. Most staff nurses/midwives believed that CNSs/CMSs were not undertaking research. There was general agreement among all the staff nurse/midwife focus groups that the advocacy responsibility of the role was fulfilled by most CNSs/CMSs.

Two staff nurse/midwife groups asked for the five core concepts to be identified before they commented. This indicated a lack of understanding of the core concepts on the part of some staff nurses/midwives; most, however, were aware that the CNSs/CMSs operate at the level outlined by the National Council.

Clinical managers' perspective

Clinical managers differed in their perceptions of the core concepts. Some believed that the ability to operate to the level of the core concepts was a matter of personality. Several suggested that some CNSs/CMSs were ambitious and keen to fulfil the requirements of the five core concepts and others were not. In spite of the existence of the core concepts and the job description guidelines, there was a view that, because there was no uniform agreement on the functions attached to the role, CNSs/CMSs were operating differently nationwide. Interestingly, this was seen as negative, rather than as a flexible, innovative and individualistic response to care delivery.

As was the case with the CNSs/CMSs and the staff nurses/midwives, the clinical managers were mostly agreed that the education function was the key one, with evidence-based specialist care, clinical expertise, policy and guideline development, and practice development being cited as paramount to the role.

There was some discussion among clinical managers, as was the case with the directors, about the need for more time to be devoted to improving the research aspect of the role. Some said that the research function was underutilised; several believed it was enough that CNSs/CMSs disseminated research and adopted a research/evidence-based approach to their care.

'To provide evidence-based specialist care as distinct from a generalist.' (clinical managers)

There was some agreement among clinical managers that, as the role develops and progresses, so the workload increases. This in turn could make it difficult to judge how time was spent and consequently make it difficult to present a well-argued case for resources.

Research was the component of the five core concepts seen by clinical managers as being the least utilised, with audit being the next least utilised. There was some confusion about the research component. Many clinical managers felt that CNSs/CMSs must be undertaking their own research or be part of a research study. When probed further about whether CNSs/CMSs utilised and disseminated evidence-based research, most clinical managers agreed that the specialists had the most up to date clinical practice, which was soundly based on research.

4.2 Role preparation

As reflected in the literature, preparation for the post of CNS/CMS was perceived as crucial to the successful development of the role; this included getting 'buy in' from all staff involved. Some CNSs/CMSs used their innovation and assertiveness skills to establish themselves in the post. There was a perception among those CNSs/CMSs who did not have good support, that the position would not have proved successful had they not had the drive and motivation to make it work. Personal motivation was cited in the questionnaire by 88% of respondents as a factor that helped them develop their role.

Clinical managers felt that they ought to have been involved when CNS/CMS posts were being planned. This confirmed the findings from the questionnaire –- only 47% of CNSs/CMSs felt that support from management helped them develop their role, which suggests that the clinical managers were perhaps not as involved as they might have wished (see Table 9).

This lack of involvement has more to do with internal strategic planning than with the efficacy of the CNS/CMS role. However, it affects how the CNS/CMS is received upon appointment. It is fair to assume that new posts are more likely to be integrated smoothly where all staff are consulted and involved in planning services. Having an agreed job description, which has been drawn up collaboratively by all the relevant staff, was regarded as crucial to successful role preparation.

'Having a proper job description before job is advertised.' (CNS/CMS)

The CNSs/CMSs believed that having support from the medical staff was vital for the successful development of the role. The questionnaire supported this view with 59% stating that having support from medical staff was a factor that helped develop the role. However, data from the focus groups suggested that while having the support of the medical staff was seen as important for the successful development of the role, this support was not necessarily always forthcoming.

'Consultants didn't really know what to expect of us, they aren't aware of what we are capable of, they aren't tapping into our full potential.' (CNS/CMS)

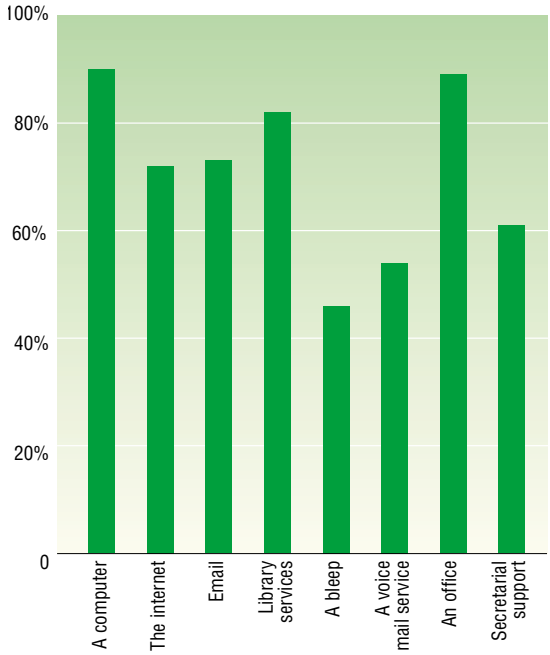
Here again is evidence of a 'bedding down' phase for some CNSs/CMSs, who believed that it was up to them to prove their worth to their medical colleagues.

Table 9:
factors that helped develop the role

Factors	%
Clinical experience	94
Personal motivation	88
Own communication skills	86
Own understanding of role	70
Continuing professional development	68
Academic qualifications	61
Acceptance of role by medical staff	59
Networking with nursing/midwifery colleagues	59
Acceptance of role by multidisciplinary team (other than medical staff)	52
Support from other CNSs/CMSs	50
Support from management	47
Acceptance of role by nursing/midwifery colleagues	44
Good organisational structure	36
Good introduction/orientation	17

Having the necessary resources in place before the post is established was seen to be important. Resources included having an office, or at least a computer, access to the library and secretarial support. Of respondents to the questionnaire, 89% had an office and the same percentage had a computer with 73% and 72% having access to email and the internet respectively. Secretarial support was available to 60%, but it was not clear how frequent or formalised this support was. Some CNSs/CMSs in the focus group stated that they had no access to secretarial support and others stated that this was available sporadically (see Figure 7).

Figure 7:
resources available to respondents



Some CNSs/CMSs did not have these supports when starting out, many said that they had to 'fight' for their resources. Having a role model was perceived by the CNSs/CMSs to be important.

There was general agreement that when the role was new, it took time to get people to appreciate the concept of the CNS/CMS. Where nursing and medical staff accepted the role, CNSs/CMSs said that it had been easier to develop the service. Pre-planning of the post included briefing all staff who would have contact with the CNS/CMS.

'Staff on the ground, I find staff have an appreciation of the work we do, there was no-one before where they could refer, so they appreciate us.' (CNS/CMS)

Results from the questionnaire indicated that only 44% of CNSs/CMSs identified acceptance of the role by nursing/midwifery colleagues as a factor that helped develop the role. Implicit in this is the probability that a large percentage of CNSs/CMSs did not receive support from their nursing/midwifery colleagues (see Table 9).

Some focus group participants said that the CNSs/CMSs were more assertive than other staff; this was felt to be due to the enhanced education that they received, and thus education was felt to be important for role preparation. This perception is borne out once again by the questionnaire findings –- 68% and 61% of CNSs/CMSs felt that academic qualifications and continuing professional development were factors that helped develop their role (see Table 9).

Where the introduction of the role was preceded by information sessions for staff nurses and midwives the role was reported to have been more successful, because role ambiguity could be ironed out early. The questionnaire responses however, showed that only 17% of CNSs/CMSs believed that good orientation or introduction helped them to develop the role. It is not clear if the CNSs/CMSs actually had an orientation period.

4.3 Success of the CNS/CMS role

The question as to whether the role was valuable or not elicited the most assertive and the most positive responses from all the focus groups.

'Oh yeah, absolutely.' (DoN/DoM)

'Provides research, evidence-based.' (clinical managers)

Directors of nursing/midwifery and the clinical managers regarded the role as empowering, allowing nurses/midwives to pursue their specific area of interest within the framework of a career pathway.

'It created pathways for nurses.' (DoN/DoM)

'It empowers nurses to develop outside the boundaries.' (DoN/DoM)

'An avenue of promotion.' (clinical managers)

Directors of nursing and the clinical managers were of the view that because healthcare is becoming more and more specialised, the development of the CNS/CMS role is fitting and timely.

'A sense of change since the Commission, taking ourselves by the scruff of the neck, more expectations on nurses, everything is research-based.' (clinical managers)

'As healthcare is becoming more specialised it is fitting within this model.' (DoN/DoM)

The overwhelming opinion of the focus groups was that the CNS/CMS made a difference to the quality of patient/client care.

'Yes, a very valuable resource, the wounds heal quicker, the patients go home quicker.' (managers)

'We need more.' (clinical managers)

It was agreed that there were benefits to be gained from the CNS/CMS role but the work of staff nurses/midwives needs to be an acknowledged. Staff nurses/midwives were in agreement with directors that the CNS/CMS role had a positive impact on the quality of patient/client care.

'Patients are better educated going home.' (staff nurses/midwives)

'The CNS/CMS – is a great experience for patients, they can allay their fears.' (staff nurses/midwives)

It was believed that the reason for this positive impact on patient care was because CNSs/CMSs had more time to talk to the patients/clients and because they had more up to date information than other staff. Other staff felt they did not have the time for patient/client education and that in any event the CNS/CMS had more evidence-based expertise.

One caveat to this positive response was expressed as the need for role evaluation, performance appraisal/indicators and clarification in relation to what the directors expect from the CNS/CMS. There was some critical discussion also about reporting relationships and control and management issues. Some directors were concerned about the lack of control over CNSs/CMSs; this happened apparently when CNSs/CMSs allied themselves to the medical staff and were perceived to have a medical-orientated post. On the other hand, some directors were less concerned about reporting relationships and more interested in how they could offer support and what their responsibility was in regard to the CNS/CMS.

Some directors were concerned at the negative tone of some of the discussion surrounding reporting relationships and specifically asked that this be acknowledged.

All staff nurse/midwife groups agreed that the role was worthwhile, but some participants said that ward-based CNSs/CMSs might have better served their needs.

'Medical surgical CNS would be good.' (clinical managers)

'Would like to see the development of ward-based CNS not related to specific disease.' (DoN/DoM)

The overwhelming response was that the role was successful and that patients/clients were receiving a good service from CNSs/CMSs. Directors of nursing/midwifery took the view that the role was successful but that there was still a need in some areas for role clarification. On being pressed to identify how they justified this view they responded with statements such as

'They opened up a service need.' (DoN/DoM)

A relevant specialist qualification was deemed essential, not simply for the professional development of the individual CNS/CMS but for credibility within the team and ultimately for the success of the role. The questionnaire demonstrated that 61% of CNSs/CMSs said that having academic qualifications helped develop the role (see Table 9).

The overwhelming view in the focus groups was that if the CNS/CMS had a clearly defined role, possessed excellent communication skills, had an ability to teach and could include staff nurses/midwives in decision-making, the role was successful. However, where role ambiguity existed and where the CNS/CMS excluded staff nurses/midwives from decision-making or failed to communicate changes in the patient/client programme of care, the perception of the CNS/CMS role was negative.

Clinical managers viewed audit as a good measure of the success of the role and where it had taken place, changes in care were successfully introduced. They said that CNSs/CMSs were able to take a more patient/client-orientated approach and that the continuity of care for patients/clients was a great benefit. This finding was reflected in the patient/client focus group. All participants in the focus groups referred to the extra resource that CNSs/CMSs offered staff in terms of education, audit and policy development.

A minority of clinical managers however, were of the opinion that the introduction of the role had led to fewer staff numbers on the ground. Staff nurses/midwives took a different view, they said that the extra resource was of great benefit to them and they believed that the success of the role was evident in the fact that consultants were availing of the services of the clinical nurse/midwife specialists.

'There are so many consultants, and they are now referring patients onto the CNS and that's a huge success because it recognises their function.' (staff nurses/midwives)

Being enabled not only to refer to, but also being competent to receive referrals from, other healthcare professionals was regarded by the focus groups as acceptable criteria for measuring the success of the role.

4.4 Deskilling

Staff nurses/midwives said that the CNS/CMS played a very positive part in their education and in up-skilling, although a small number believed that they were being deskilled. This small minority appeared to adopt a passive perspective, that deskilling was somehow being done to them and they had no control over it. The term used in one focus group was 'dilution' of skills. Staff nurses said that it was up to themselves not to become deskilled.

'I might get a bit lazy about finding out; I may not be as up to date as I should be.' (staff nurse/midwife)

'We would have a certain amount of skills but not as many as we should, they allow us to become deskilled.' (staff nurse/midwife)

'Because they are there you can disempower yourself, it's so easy to say let the CNS/CMS deal with that.' (staff nurse/midwife)

Most CNSs/CMSs and their clinical managers considered it to be a key function of their role to up-skill and empower the staff nurses/midwives.

'Working on wards with ward nurses is important so they are not disempowered, to ensure they are confident and competent.' (CNS/CMS)

'Big role, empowering staff to deliver the care to patients.' (CNS/CMS)

'Empowering families, making families aware of community services.' (CNS/CMS)

'Educating and empowering staff nurses rather than giving direct care.' (clinical managers)

There was universal agreement that the educational aspect of the role (both formal and informal) was of the greatest benefit to the staff nurse/midwife and helped prevent deskilling. As a result, staff nurses and midwives had more confidence, received more knowledge and more skills and thus became more competent. The only note of caution was from staff nurses who felt that they could become too dependent upon the CNS/CMS for everything. This, again, was seen mostly to be their own fault if they allowed it to happen.

'The CNS/CMS has the potential to deskill us, but we won't allow it, it's up to ourselves.' (staff nurses/midwives)

It was also widely recognised that the CNS/CMS had more time to spend with the patient/client and this was of great benefit to the staff nurses/midwives.

'Patients are more in the know with what's happening.' (staff nurses/midwives)

'If they help the patient, they help us to do our own work.' (staff nurses/midwives)

4.5 Outcome performance measurement

Some CNSs/CMSs were unaware of the concept of outcome performance measurement. Others were aware of the practice but had no experience of it and, finally, there were some who had undertaken outcome performance measurement. It was suggested that some CNS/CMS roles lend themselves to performance measurement more readily than others. A few CNSs/CMSs reported that, because much time was spent fire fighting, there was little opportunity for strategic planning and, as a result, audit and outcome performance management were low priorities. When pressed however, it became evident that many CNSs/CMSs were executing outcome measurement, but were using different terminology to describe the task. Instances and patterns of reduced waiting times, fewer hospital admissions, less complications, fewer re-admissions were noted and measured regularly, all of which are valid performance outcomes. Table 10 displays those activities that the CNSs/CMSs reported measuring. The data confirms that most (81%) measure the number of patients that they see, 50% keep a record of referrals made and 54% record referrals received; 55% measure the effectiveness of interventions and 39% measure patient/client satisfaction. However, when the measurements become more complex, the number of CNSs/CMSs who measure them decreases. For example, only 12% measure the reduction in visits to the GP, 10% measure the reduction in A&E visits and 20% measure reduction in hospital admissions.

Table 10:
percentage of respondents measuring performance outcomes

Performance outcomes	%
Numbers seen	81
Effectiveness of interventions	55
Referrals received	54
Referrals made	50
Telephone consultations	41
Waiting times	40
Patient/client satisfaction	39
Quality of life indicators	21
Reduction in hospital admissions	20
Reduction in attendance to the general practitioner	12
Reduction in visits to the emergency department	10

Almost all the directors said that CNSs/CMSs had made a positive difference to the quality of patient/client care.

'Measured improvements are now visible.' (DoN/DoM)

'The breast feeding rates have gone up.' (clinical managers)

Directors were concerned about patchiness in the measurement of quality of care, some said that their CNSs/CMSs were measuring their own work and some said that they were not. Some directors suggested that measurement was dependent on the clinical area of practice, agreeing with the CNSs/CMSs that certain clinical areas lend themselves more readily to measurement than others. Of respondents to the questionnaire, 55% stated that if they measure performance outcomes they change their practice as a result (Table 10).

'Cut down on the number of admissions.' (DoN/DoM)

'Practice development has moved forward.' (DoN/DoM)

CNSs/CMSs, like the directors, believed that they had improved the quality of care but needed to be able to demonstrate this, those who audited their work were able to do so.

'If we could do more audits we could demonstrate that we are cost effective and save money.' (CNS/CMS)

'Re-admission figures show admission figures down since appointment and ward staff commenting that they don't see as many patients returning with crises.' (CNS/CMS)

CNSs/CMSs agreed that quantitative criteria were much easier to measure but did not necessarily reflect the quality of life issues that they considered to be important. They said that clinical managers preferred facts and figures, especially when producing annual reports, whereas CNSs/CMSs thought that the focus ought to be on qualitative issues.

Clinical managers also agreed that the CNS/CMS made a difference to the quality of patient/client care, which, they said could be measured by the care setting in which patients/clients were treated. For example there were

- fewer admissions to the acute sector
- fewer visits to the GP
- shorter waiting times in outpatient departments
- better education for patients/clients
- empowerment of patients/clients to take responsibility for their own care and treatment.

Some CNSs/CMSs said that because they had not received training in the area of audit and measurement, it was unfair to expect them to engage in these tasks. They were willing to undertake audit and quality measurements if trained/educated to do so.

'Software should be available for auditing oneself.' (CNS/CMS)

Many CNSs/CMSs believed that the time they were able to spend with patients and their families was very valuable. They stated that a lot of their time was spent interpreting and translating for their patients/clients what the medical staff had said to them.

'Improved continuity for patients.' (DoN/DoM)

Fewer hospital admissions, earlier interventions and fewer complications were all regarded as legitimate criteria for measuring the quality of patient/client care. Education for the patient/client was perceived by all grades to be a good indicator of the quality of care.

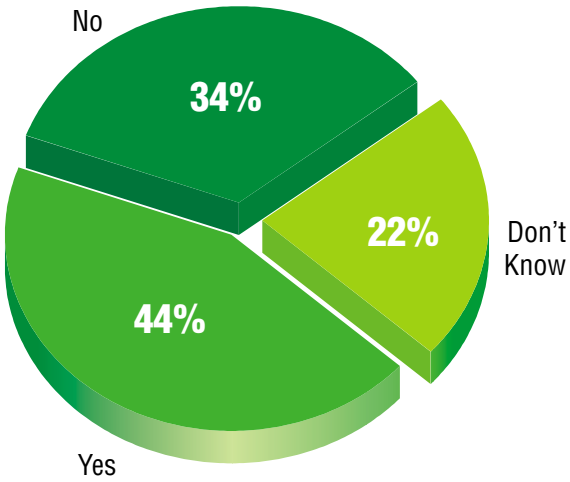
'Patients will go home a lot more content when they know they have the CNS to contact.' (clinical managers)

'Patients benefit from contact with the CNS/CMS, improves their quality of life because of education.' (staff nurses/midwives)

'By educating parents you're empowering them, that's going to keep them in the community, at home.' (staff nurses/midwives)

Having research skills and up-to-date knowledge was regarded as a prerequisite for delivering quality care. The CNS/CMS was seen as possessing the necessary up-to-date knowledge. Of respondents to the questionnaire, 45% stated that they wrote an annual report on their activities, 44% said that their organisation had a strategic vision for the development of the CNS/CMS service, and 69% stated that they contributed to the organisation's service plan (see Figure 8).

Figure 8:
percentage of respondents whose organisation had a strategic vision for the development of the specialist service



4.6 Barriers to role development

Not all CNSs/CMSs said that they were able to effect the change required to introduce new service developments.

The barriers to role development are the direct opposite to the facilitators of role preparation. Barriers to role development include lack of understanding of the role, lack of collaboration from all the relevant stakeholders, lack of resources, role ambiguity, lack of role models, lack of a CNS/CMS network and lack of continuing professional development (CPD) opportunities. Table 11 gives the percentage of respondents who experienced a range of specific identified barriers to the development of the role.

Most focus groups were concerned about the lack of availability of relevant higher/postgraduate diploma programmes. They also said that access to those programmes that were available was inequitable because most were located in Dublin. Most CNSs/CMSs said that their clinical managers were supportive of them undertaking further education.

Table 11:
percentage of respondents who experienced identified barriers to the CNS/CMS role

Barriers	%
A lack of understanding of the role by other healthcare professionals	60
Lack of resources to set up/develop the role	57
A lack of understanding of the role by staff nurses/midwives	48
Lack of secretarial support	48
Lack of access to continuing professional development	39
Lack of other managerial support	37
Lack of understanding of the role by clinical nurse/midwife managers 1, 2, and 3	32
Lack of nursing support on professional issues	31
Lack of multidisciplinary support	30
Lack of nursing support on clinical issues	28
Lack of clinical support	25
Lack of academic qualifications	19
Lack of understanding of the role by oneself	16
Lack of support from other CNSs/CMSs	12

Some directors reported problems with the CNS/CMS role, such as working office hours only, role conflict, lack of clarity in reporting relationships, monitoring of CNS/CMS activity, exclusivity and isolation.

'Some (CNSs/CMSs) align themselves to a medical specialty and don't accept line management from nursing.' (DoN/DoM)

A group of clinical managers said that it had taken time to get to grips with the role. They readily took responsibility for this themselves, saying that they may not have tapped into the potential of the role. Some clinical managers recommended that the service should be available twenty-four hours a day, seven days a week.

One director commented that the 'grandfather approach' to appointing CNSs/CMSs under the immediate pathway had been a mistake. Other directors said that there was a lot of room for development of new posts, with nurse-led services becoming more prevalent.

All respondents to the questionnaire could refer to other healthcare professionals and all received referrals from the same healthcare professionals (see Table 12 for a breakdown).

Table 12:
percentage of CNSs/CMSs who can refer and receive referrals from other healthcare professionals

Healthcare professional	Refer to	Receive referrals
Medical staff	73	80
Public health nurse	63	47
Other CNSs/CMSs	57	50
Social worker	56	31
Dietician	49	19
Occupational therapist	38	16
Psychologist	37	22
Physiotherapist	36	15
Community mental health nurse	28	24
Speech therapist	21	8
Radiographer	11	4
Staff nurses/midwives	N/A	49
CNM 1, 2 and 3	N/A	44
Self-referrals from patients/clients and relatives	N/A	54

A small but vocal number in some of the CNS/CMS focus groups believed strongly that the development of the role in certain divisions of the register was inequitable, the geographical spread was uneven, and the creation of new posts was not given precedence. Some expressed their dislike of the use of certain titles, suggesting that the title did not in any way reflect the job that was actually being done. The use of titles is discussed in section 3.3.

Some CNSs/CMSs said that there was no need to further develop the role – a minority were strongly of the view that there was no need for additional education.

The disparity regarding role development suggested that CNSs/CMSs operate at different levels; some have been able to develop the service in line with their personal vision, others, for varying reasons, have not.

Small care settings were seen as a hindrance to development of the role. There was a perception that the bigger the organisation/institution the greater the scope for role development.

There was some discussion about the notion of a career cul-de-sac. Some believed that becoming a CNS/CMS closed off the managerial and educational route and that the only career progression was to ANP/AMP. Not all CNSs/CMSs wished to become an ANP/AMP although some said that they would like to know more about progression to that level. The issue of burnout was discussed briefly – participants felt that burnout could occur and, when it did, the career pathway choices were minimal. Some cautioned that because pre registration teaching will be reduced due to the degree programme there is a risk that teaching skills will be lost. The CNSs/CMSs said that it was important to update/improve their teaching skills.

4.7 Service developments

CNSs/CMSs were questioned in their focus groups about their ideas on innovation in service development. Their suggestions are discussed below.

Nurse/midwife prescribing was regarded as essential for service development by all CNSs/CMSs and most were aware of the Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products Project.

Nurse/midwife-led clinics were suggested as a possible area for further development; however, it was felt that, if this were to happen, the medical staff had to be supportive.

Some CNSs/CMSs saw a need to produce more information/education leaflets for their patients/clients; this was regarded as part of role development.

The ordering of tests and diagnostics was suggested as an area where service could be developed because this promoted an element of independent practice without which role development would clearly be restricted.

Some CNSs/CMSs suggested that admission and discharge rights should be further examined.

Clinical managers in the acute sector saw a role for the CNS/CMS in medical and surgical areas, particularly in support of the degree programme students.

Suggestions from CNSs/CMSs for improving service development were entirely patient/client focused. This indicates that CNSs/CMSs have a very patient/client orientated approach to their service, an approach which should be applauded. The discussion around the issue of role or service development actually elicited the liveliest discussion, suggesting that most CNSs/CMSs have an abundance of ideas for the development of the service and ultimately the improvement of the care they can deliver to their patients/clients.

4.8 Personal qualities

All focus groups discussed the concept that the personality of the CNS/CMS was a crucial factor for the success of the role. Remarks such as 'the CNS/CMS needs to be an achiever, an innovator and have a sense of humour' were heard repeatedly.

There was consensus that the efficacy of the role was to a great extent dependent on the communication skills of the individual CNS/CMS. Staff nurses/midwives regarded the ability of the CNS/CMS to communicate well to be the crucial skill for the role to be effective. Additionally they agreed that it was important for the CNS/CMS to be easily identifiable and accessible.

'Better rapport if their communication is better.' (staff nurses/midwives)

Where communication was seen to be poor, it affected the efficacy of the post. CNSs/CMSs believed that they had to have the ability to 'relate' to a wide cross-section of people and be able to switch easily from working as part of a team to working on their own.

Some clinical managers stressed the importance of CNSs/CMSs being recognised as role models, and that this only came via clinical credibility. It was reported that there was some resistance to the role initially and that CNSs/CMSs had to be well motivated to overcome this barrier. Clinical managers believed that the introduction and integration of the role had been successful and would only continue to be so with excellent orientation and communication skills. Clinical managers said that the achievement of this was up to the individual CNS/CMS.

Table 13 lists the range of qualities seen by all the grades as required in order to function as a successful CNS/CMS. The qualities are clearly diverse and not every CNS/CMS is likely to possess all. It is interesting to note the wide-ranging nature of the qualities outlined by the groups – this echoes the comment of one CNS/CMS that they have to be all things to everyone.

'You are expected to be perfect, I want to be able to solve everything, but I know I can't, there is a certain expectation.' (CNS/CMS)

Table 13:
perceived qualities described by all focus group participants as necessary to successfully fulfil the CNS/CMS role

confident	skilled in presentation	accessible
expert	familiar with research	interpersonally skilled
a strategist	a good team worker	having broad knowledge
assertive	good communicator	mature
an achiever	able to give direction	dynamic
self-motivated	networker	impartial
autonomous	self-developer	a challenge to status quo
specialist trained	knowledgeable of area	experienced
able to work alone	self-manager	with partnership approach
innovator	competent	humorous
change facilitator	basic information giver	a politician
IT skilled	organised	able to prioritise
a good listener	knowledgeable	time manager
educated	patient	having empathy
a genuine interest in specialist area	influencer of medical opinion	able to cross boundaries
people person	open and friendly	approachable
flexible and adaptable	a strong person	problem solver
a good negotiator		

The expectation from all focus group participants, including CNSs/CMSs, regarding the personal qualities required to be a successful CNS/CMS, was of an all - encompassing and well rounded person, with superb communication skills, detailed clinical knowledge, expertise in change management and capable of challenging the status quo; a person who at all times, in spite of the work load and stresses involved with the job, was amenable, agreeable, tolerant, commonsensical and patient.

4.9 Education of staff nurses/midwives

Education was widely regarded as an important tool that prevented staff nurses and midwives from becoming deskilled (see above section 4.4). We now examine the education issue from a wider perspective.

The directors of nursing and midwifery suggested that some CNSs/CMSs were more adept at the education of staff nurse/midwives than others. Some directors wanted to see this aspect of the role developing more, while others feared that, as the role evolved the CNS/CMS would become less operational and more practice-development orientated.

Directors said that education sessions for staff nurses/midwives were generally ad hoc and difficult to co-ordinate. This was due to time constraints, changing shift patterns and the issue of releasing staff for formal education. Short, sharp education sessions were seen as the most effective. It was felt that CNSs/CMSs should be delivering teaching sessions aimed at empowering staff nurses/midwives to deliver care at a higher level.

Clinical managers had different views about education. Most felt that CNSs/CMSs did contribute effectively, albeit with variation in performance across care settings and speciality. Some clinical managers said that CNSs/CMSs were good at one-to-one teaching but needed more training in presenting formal education sessions. Where the CNS/CMS had more clinical input, the predominant view was that there was less time for formal teaching.

'Would like to see this part of the role developing more, rather than taking over aspects of care.' (clinical managers)

Clinical managers reported that CNSs/CMSs were complaining that much of their teaching was repetitive. Releasing staff for formal teaching was a major concern for managers and was inimical to effective teaching; so also was changing shift patterns – in this, they were in agreement with the directors. There was a sense that teaching time ought to be protected and clinical managers agreed CNSs/CMSs were the best people to educate and teach because they were seen as the most up to date and qualified in terms of the knowledge they possessed.

Figure 9:
type of feedback received

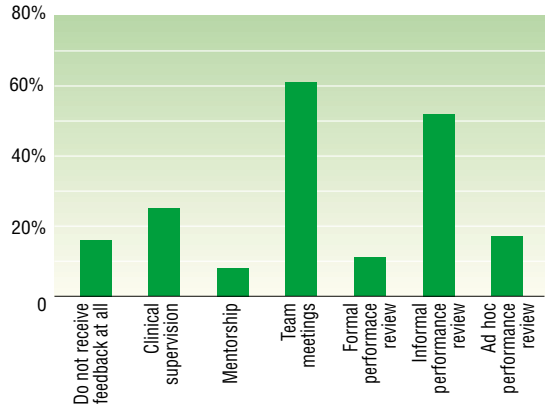
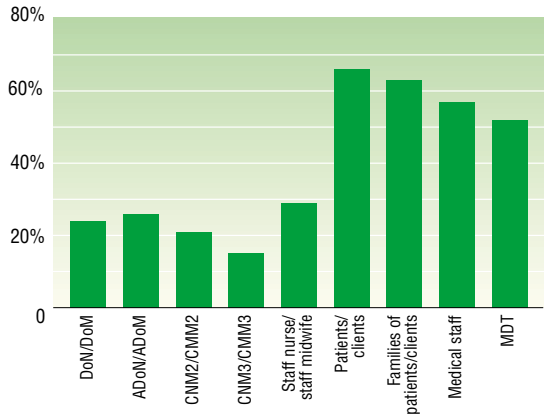


Figure 10:
who gives the feedback



There was some discussion among CNSs/CMSs about 'intuitively' knowing whether or not one is providing a good service. It was agreed however that feedback from patients/clients, families and significant others was a reliable indicator of good service.

Staff nurses/midwives stressed the importance of CNSs/CMSs giving feedback and being more available to them. Feedback from staff nurses/midwives to CNS/CMS was received by 29% of respondents to the questionnaire. Only 15%-26% stated they received feedback from their line managers (see Figure 10).

4.10 Performance review/feedback

Some CNSs/CMSs received formal feedback on their performance from their line managers, but this was the exception. Of respondents to the questionnaire, 16% stated that they did not receive feedback at all, 11% stated they had a formal performance review and 52% stated they received informal feedback. This confirms the findings from the focus groups where most CNSs/CMSs stated that they received ad hoc performance review. Feedback is clearly an unplanned process that varies across locations (see Figure 9).

Some CNSs/CMSs said that feedback from their patients/clients and nursing/midwifery colleagues empowered them and enabled them to fulfil the requirements of their role more successfully. This is confirmed by the questionnaire where 66% stated that they received feedback from patients/clients and 63% reported receiving feedback from the families of patients/clients.

4.11 Guidelines, policies and procedures

The contribution of CNSs/CMSs to devising policies, procedures and guidelines was regarded highly by the directors of nursing/midwifery, staff nurses/midwives and clinical managers. Directors felt that practice development had been able to move forward positively because of the introduction of the CNS/CMS.

'Definitely, the amount of evidence-based protocols and guidelines is superb.' (DoN/DoM)

All focus groups agreed about the impact of the CNS/CMS role on the quality of patient/client care, as reflected particularly by the significant quantity of guidelines, policies and procedures developed by CNSs/CMSs.

'Work that was done previously but never recognised is now in protocols and policies which means everyone is carrying out the same standard of care.'
(DoN/DoM)

Clinical managers suggested, however, that CNSs/CMSs could be more active in developing guidelines and policies for care delivery that would empower staff nurses and midwives to provide improved and informed patient/client care.

Staff nurses/midwives had mixed views regarding the contribution of the CNS/CMS in writing guidelines and policies. They believed strongly that CNSs/CMSs should be involved (if not actually taking the lead) with all the relevant stakeholders in helping to develop guidelines and policies; in the absence of which, CNSs/CMSs could be accused of deskilling and thus disempowering the staff.

'They are experts in their particular field, but they probably should be involved in policy making, I'm not sure how involved they are.' (staff nurses/midwives)

Some staff nurses/midwives said that because the CNSs/CMSs had such experience and breadth of knowledge they ought to be involved in devising guidelines and policies. Others reported that CNSs/CMSs with whom they worked did, in fact, devise guidelines and policies. These mixed views suggested a disparity in the amount of involvement from CNSs/CMSs in writing guidelines and policies.

4.12 Interweaving themes

Some themes occurred throughout the focus groups that do not warrant in-depth treatment individually, but nevertheless need to be identified. They are outlined briefly as follows:

Teamwork was nominated generally as being at the heart of good care across the disciplines – everyone working and communicating together effectively for the benefit of the patient/client. There was a comment that junior doctors change every six months but CNSs/CMSs are always there. They provide continuity and can be less intimidating than doctors who 'bring the whole team to the bedside'.

'Bringing the multi-disciplinary team together.' (DoNs/DoMs)

However, as has been seen, if communication between staff nurses/midwives and CNSs/CMSs is not good, a lot of unnecessary anxiety can ensue.

'Must be part of team, otherwise may be destructive.' (DoNs/DoMs)

The majority of CNSs/CMSs appear to work Monday to Friday from 8am - 4pm or from 9 am - 5 pm. This routine appears to create some tension in the workplace, with clinical managers clearly stating a preference for some diversity in working hours. Only 3% of CNSs/CMSs work evening shifts at weekends. It is interesting to note that mangers did not feel that they could influence the working hours of CNSs/CMSs in spite of the service need.

The linkage between primary and acute care where it operated effectively was seen as a huge benefit to both staff and patients/clients. This opinion was surprising because it was generally apparent that there was little communication or linkage between the acute and primary sectors. Where such linkage did exist, the transition was seamless and was seen to be of great benefit to the patient/client. CNSs/CMSs in both sectors felt they had a lot to learn from each other about their different care settings and treatment plans.

'Some are involved in the links between secondary and primary care, educating general practitioners and practice nurses.' (clinical managers)

'Interdisciplinary movement between nurses is great, for example one mental health nurse accessed the general CNS for wound care.' (staff nurses/midwives)

Clinical managers said that in some places, dual roles exist, with some CNSs/CMSs working 0.5 of a wholetime equivalent as a specialist, and the other 0.5 as a staff nurse/midwife or, in some cases, as a clinical manager. While it is understandable why this situation exists, it can cause difficulties not just for CNSs/CMSs, but also for those staff who are working with them. CNSs/CMSs who are working in two roles, are working in different sites, and experience problems of accessibility to staff, patients/clients and colleagues. CNSs/CMSs who were employed in a dual role capacity found that this caused confusion and led to lack of understanding about the role among other healthcare professionals. Where the level of service did not warrant a full-time post, it was suggested by the clinical managers that the post could be conferred with a broader local or regional focus.

Networking on a local, regional and national basis was regarded as extremely useful, even if just to confirm that one is 'doing the right thing'. Most CNSs/CMSs agreed that there was potential to be isolated in the post, so that networking with colleagues was crucially important. It also meant that information was shared and knowledge updated.

All focus groups commented on the benefit of getting together to talk about the role, to share insights into different roles and to discuss solutions to problems. Those CNSs/CMSs who did not have a network, spoke positively about the benefits of simply being in the same room and discussing mutual issues with colleagues. The value of the focus group is in this regard worth noting – Stevens (1996) terms it 'the consciousness raising effect'.

The pilot project for CNSs/CMSs run by the NMPDU in the South Eastern Health Board and funded by the National Council, was described by those involved, as very worthwhile. Each commented on the value of a group of twenty CNSs/CMSs meeting regularly to examine ways to enhance the professional role and to support each other. One outcome of the programme is that a role resource pack has been adopted for all CNSs/CMSs. The pack is an invaluable tool for the exploration of issues such as

- role clarification
- the competencies required to effectively embrace the five core concepts
- approaches to personal development planning and portfolio building
- audit of role and service delivery
- research utilisation and promotion
- tools available for data collection and analysis
- annual report writing and
- service plan submissions.

The pack may be used as a stand alone resource or in tandem with a complementary education programme, which would depend on resources available locally (see Chapter 2.6).

The benefits of introducing a link nurse or midwife for the CNS/CMS were acknowledged. All grades of staff agreed on the value of the link nurse or midwife and that becoming one was a good foundation for progressing on to CNS/CMS in the future. A link nurse/midwife is described as a nurse or midwife who has developed an interest, received training and pursued ongoing education in the principles, philosophies and practices of their particular area of care, while remaining a generalist rather than a specialist expert in that particular area of care. Link nurses will understand the knowledge, skills and attitudes appropriate to their area of specialist care which they will promote and facilitate (Maddocks 1999).

Participants said that if the staff nurse/midwife could work one-to-one from time to time with the CNS/CMS, he/she would be better equipped to cope with situations arising when the CNS/CMS was not on duty.

4.13 The differential

There was much discussion in the focus groups about what constitutes the difference between an experienced staff nurse or midwife and a CNS/CMS. This discussion occurred in spite of the guidelines issued by the National Council and is worth noting for that reason.

Expertise, knowledge and experience were the three attainments that most CNSs/CMSs believed marked them out as clinical nurse/midwife specialists. Having the autonomy to fulfil service requirements and having a strategic vision were also seen as important traits.

'Because the role is so specialised, they have the most up to date knowledge and can pass this on.' (staff nurses/midwives)

'Ability to pull all core concepts together.' (CNS/CMS)

All CNSs/CMSs agreed that having a pioneering attitude and being able effectively and holistically to respond to their patient/client needs were crucial. This is in line with the personal qualities required for the role as discussed earlier.

'Prepared to stick your head over the barricade – a pioneer.' (CNS/CMS)

Some CNSs/CMSs said that being able to cross the boundaries of care settings was the most exhilarating aspect of their role; they said that other healthcare personnel were less able to do this.

'We bridge the gaps.' (CNS/CMS)

The autonomous nature of the role allowed CNSs/CMSs to practice as they felt necessary, rather than being confined to rigid task-orientated situations.

'Freer to be yourself with patients' (CNS/CMS)

Having one's own caseload was frequently cited as a determining factor that marked the difference between the CNS/CMS and other nurses and midwives.

'Lots of direct contact.' (CNS/CMS)

'Patients feel that we have time to give them.' (CNS/CMS)

'The patient can clearly identify you as the person who tends to link their care together.' (CNS/CMS)

Some CNSs/CMSs thought the title 'Clinical Nurse/Midwife Specialist' was incorrect, the word 'specialist' being too specific. They argued that due to the breadth and diversity of their practice they were not necessarily really specialists in only one area. An alternative suggested title was 'Clinical Nurse Practitioner'.

Decision-making was mentioned as an important indicator of the role of the CNS/CMS.

'Think on your feet, make unilateral decisions and it's your responsibility, no passing of the buck!' (CNS/CMS)

4.14 Patient/client focus group

Patients in one health board were invited to participate via the Director of Nursing who acted as a contact point. Patients'* responses were predominantly and warmly positive when asked to comment on how the role of the CNS/CMS affected their care. They saw the CNS/CMS as a true professional and an expert in the clinical field. The key role of the CNS/CMS was perceived as that of a translator and an educator.

'She translated for me what the consultant was talking about, not to say the doctor wasn't fantastic, but there was so much to digest she helped me focus.'

'They made sure we understood.'

'They wouldn't let me out until I had watched a video.'

'The cardiac rehab programme was fantastic, we didn't want it to end, there was so much care.'

'She went through all my medication, explained what each tablet was for and why and when I had to take it and the side effects.'

The counselling role was thought to be of considerable benefit to the patients.

'She was always available after the oncology visits, she could see I was upset, she was there as a listener, someone who could empathise, she followed me up at home, she contacted my GP and he came to see me, she made sure I was okay.'

'She got in touch with my husband to make sure I was alright.'

As alluded to earlier, patients were conscious that the CNS/CMS was available to them as a constant contact, and so they felt that the continuity of their care was intact.

'I always felt that she was there, I could ring her at any time.'

'You know they are there, we don't want to contact them out of hours, they work so hard, but knowing that we can if we need to is the great thing.'

'My life line is the CNS, she is always at the end of the phone, she even gave me her mobile phone number when she was away.'

'The nurses are fantastic, they should get paid more than the government.'

*The patients specifically asked not to be referred to as customers or clients, preferring to be termed *patients*.

Patients also had the perception that the CNS/CMS acted as the conduit through which all of their healthcare was organised, for example the diabetic CNS/CMS not only managed the diabetes aspect of care but co-ordinated other aspects of patients' health.

'She sorted out my early admission for colonoscopy; she facilitates all of my healthcare.'

The patients thought that the CNS/CMS was a valuable resource for other staff.

'The ward staff couldn't operate without them.'

'The staff were lifted when they walked onto the ward.'

All patients had had excellent experience of and reaction to the role. They agreed that the CNS/CMS was in total control of their healthcare pathway. The feeling of confidence that the CNS/CMS inspired 'rubbed off' on them and gave them a feeling of overall confidence in their treatment and the decisions about their care options.

'She gave me a lot more information as to what was going to happen in the future and she was clear about the choices I had; I knew from talking to her what I was going to do.'

'It was very new for me, I didn't know what was going to happen, she really set my heart at ease, it wasn't really going to be a big thing.'

Patients obviously hold the role in high regard – they thought more CNSs/CMSs should be in place because those in the post were so busy. Their views confirm the findings of the survey *National Patient Perception of the Quality of Healthcare (*2002) undertaken by the Irish Society for Quality and Safety in Healthcare, which showed that the quality of care and service that patients receive was perceived to be very high. One comment summed it up:

'What the CNS did was to really humanise my experience, it was like meeting a close friend who was also objective and had a lot of information – so, better than a close friend.'

4.15 Summary

The data presented above reflects the information collated from those CNSs/CMSs who responded to the questionnaire and from the directors, clinical managers, CNSs/CMSs, patients/clients and staff nurses/midwives who attended the focus groups.

The focus group content analysis has demonstrated that there are many issues and concerns about the role of the CNS/CMS from many differing perspectives. It is apparent particularly that the CNS/CMS role in Ireland exists on a developmental continuum.

The focus group themes and the data collated from the questionnaire essentially reflect the findings of the literature review. Those CNSs/CMSs who have been in post for long periods of time do not have concerns about role acceptance or understanding; instead they are looking for specific systems and processes that will help appraise their roles and underpin the perceived benefits to service delivery and ultimately patient/client care.

The CNS/CMS responds to service in a flexible and innovative manner, an example of this being the establishment of nurse/midwife-led clinics – this is a real strength of the role. Where progress of this kind has yet to happen, clinical managers and CNSs/CMSs have a clear responsibility to review service provision within their area.

The clinical aspect of the role was regarded as very important by all staff. It was generally acknowledged that excellent clinical experience helped to develop the role; again, this was seen as a great strength of the role. The educational aspect of the role requires some development, but where an educational structure was well established, it was perceived to be of great benefit to staff nurses/midwives and to the patient/client.

For many CNSs/CMSs, the audit aspect of the role has not been fully embraced. There seems to be a lack of managerial expectation that CNSs/CMSs will audit their role and there is a consequent lack of resources to support the education and training of CNSs/CMSs in up-skilling their audit techniques. The role of audit will need to be made more explicit when job descriptions are being prepared and managerial feedback to the CNS/CMS should include discussion around audit techniques. There must be investment to develop skills in audit. Educators need to ensure that curricula include audit skills as a matter of course.

The writing of guidelines, policies and procedures was also regarded as a real strength of the role, enhancing and empowering the role of the staff nurse/midwife. It is crucial to emphasise that the CNS/CMS does not work in isolation. It was a repeated perception throughout the focus groups that the CNS/CMS is the person who can link or bring the team together. This can be effective only if the CNS/CMS shares and disseminates her/his knowledge.

Only 23% of those who responded to the questionnaire had undertaken a higher/postgraduate diploma*. Those that have not engaged in CPD should be actively encouraged to do so; this is evident in the weight of data from CNSs/CMSs indicating that their academic achievements aided them when establishing and developing the role.

There are areas of concern remaining for many of those working as clinical nurse/midwife specialists and those working with clinical nurse/midwife specialists. These concerns mirror the issues that are well documented in the literature – issues such as role preparation, lack of adequate resources and role ambiguity have been, and, in some cases, remain areas of concern. Deskilling, although anecdotally given credence, in reality appears to be only of minor concern to staff nurses and midwives. CNSs/CMSs see themselves as empowering and acting as a vehicle for passing on knowledge and expertise to their colleagues. Staff nurses/midwives see the CNS/CMS as a valuable resource and a reservoir of knowledge and clinical expertise.

*This low figure could be accounted for as the majority of CNSs/CMSs (1359) were approved under the immediate pathway, where having a higher or postgraduate diploma was not a requirement. The question was not asked about those CNS/CMS who may have been undertaking further education at the time of the questionnaire.

CHAPTER 5

‘Big role empowering staff to deliver the care to the patients’

(CNS/CMS)

Conclusions, future developments and recommendations

5 Conclusions, future developments and recommendations

5.1 Conclusion

This research study demonstrates that the introduction of the role of clinical nurse/midwife specialist in Ireland has been successful. The cohorts of CNSs/CMSs in post have clearly embraced the core concepts of the role and have been empowered to improve the quality of care for patients/clients: there is overwhelming support for the effectiveness of the role of clinical nurse/midwife specialist. It is clear that there is great potential for the role to develop as it continues to respond to service need.

The international experience of clinical specialism in nursing/midwifery shows a continuum of development from the 1970s to the early 1990s. The role has developed onwards from a 'bedding down' phase of role ambiguity, acceptance of the role and role clarification. Thereafter the movement has been in the direction of role evaluation, value for money, performance outcomes and the transition to advanced nurse/midwife practitioner (ANP/AMP). This continuum is reflected in the Irish experience as is evidenced in the data collected for this study. For many CNSs/CMSs, the audit aspect of the role needs further development. The role of audit will need to be made more explicit when job descriptions are being prepared and managerial feedback to the CNS/CMS should include discussion around audit techniques. Audit skills need to be developed and educators need to ensure that curricula include audit skills as a matter of course. Deskilling, although anecdotally given credence, in reality appears to be only of minor concern to staff nurses and midwives. CNSs/CMSs see themselves as empowering and acting as a vehicle for passing on knowledge and expertise to their colleagues. Staff nurses/midwives see the CNS/CMS as a valuable resource and a reservoir of knowledge and clinical expertise.

As healthcare and social care services develop so too does the scope of practice of specialist roles. Continual re-evaluation of the progress and appropriateness of specialist nurse/midwife roles ought to be part of every healthcare organisation's service plan. Support should be provided in this re-evaluation process at regional level by the NMPDUs and at national level by the National Council. The guidelines provided by the National Council with regard to role definition and educational preparation have provided a robust foundation upon which to build the capacity of nursing and midwifery specialist posts.

It is important to emphasise that the CNS/CMS does not work in isolation. It was a repeated occurrence throughout the focus groups that the CNS/CMS is the person who can link or bring the team together. This can be effective only if the CNS/CMS shares and disseminates her/his knowledge. It is important for the integration of the CNS/CMS role that the postholders create a strong working relationship with clinical managers, staff nurses and staff midwives. This relationship should be supported by ongoing feedback from line managers.

It is clear that the development of the CNS/CMS role in Ireland is in its early stages. The CNS/CMS is in a key position to contribute to the successful implementation of the health service reforms. CNSs/CMSs will support the implementation of national health policy, in particular the national health strategy *Quality and Fairness: A Health System for You* (DoHC 2001a) and the *Report of the National Task Force on Medical Staffing* (DoHC 2003a). The *Report of the National Task Force on Medical Staffing* concludes that the CNS/CMS role is already well defined and is in keeping with the Task Force's concept of utilising the skills of healthcare professionals to best effect. However the report stresses that this development must occur in a planned and coordinated way and that the acquisition of skills and qualifications will require a lead in time. It is envisaged that an expanded decision-making role for nursing staff will be actioned by 2005. This means that nurses and midwives are ideally placed to expand their practice and develop nurse/midwife-led services, within the policy context.

In a response to the *Report of the National Task Force on Medical Staffing (*DoHC 2003a*),* the Nursing Policy Division in the Department of Health and Children, published *The Challenges for Nursing and Midwifery: a Discussion Paper* (DoHC 2003d). The discussion paper outlines the critical success factors necessary for nursing and midwifery to respond appropriately to the challenges set out by the Task Force. These include management of change, partnership, leadership, educational and professional development, competence and clinical guidelines. The document identifies the key development issues facing nursing and midwifery in the future. It identifies a range of possible developments for nursing and midwifery elicited from nurses and midwives in acute, psychiatric and midwifery settings; these include nurse-led admission, discharge protocols, nurse-led minor injury clinics and pre-assessment clinics. The Task Force has developed an implementation plan, which includes nursing and midwifery.

The National Task Force on Medical Staffing selected two regional pilot sites to explore the proposed reconfiguration of services. A series of workshops held with nurses in these two pilot regions identified a number of areas in which nurse-led clinics were already running and which could be provided in other hospitals. These included pre-assessment clinics, respiratory clinics and minor injury clinics (DoHC 2003). The NMPDU in the Mid-Western Health Board (MWHB) published *Supporting your needs: An Explorative study into the Expansion of Nursing and Midwifery Professional Roles in Response to the European Working Time Directive* (MWHB 2003). The report outlines in detail the findings from 38 focus groups. Nurses and midwives in the MWHB identified the range of opportunities and challenges facing them

in the future. Nurses and midwives enthusiastically embraced the challenge that the reduction in non-consultant hospital doctors hours present but feel that the focus must be on role development and not on task transfer. A regional inter-disciplinary consensus approach will be taken in order to implement the findings of the report. The report is available on the National Council website **www.ncnm.ie.**

The CNS/CMS role has been able to respond to service demands in a flexible and innovative manner: examples of this are the establishment of nurse/midwife-led clinics and the development of specialist posts across services at regional level. There is great potential within these specialist roles to assist the integration of primary and secondary care. The vision and strategic plans of the service providers, the directors of the NMPDUs and the National Council are crucial to ensure the appropriate development of CNS/CMS roles. In order to ensure the sustained development of CNS/CMS roles in response to service need, there must be planned and co-ordinated review at local, regional and national levels. This should be closely linked with the service planning process.

5.2 Future developments

This section discusses the potential future developments of the post of clinical nurse/midwife specialist by division of the register. All future developments must occur in the context of service need and be established within the framework of the service plan.

The *Agenda* document (National Council 2003) highlighted areas for development within the nursing and midwifery professions which included areas for CNS/CMS development. This document provides the context for such developments.

5.2.1 General nursing

To date, many CNS roles in general nursing have developed around symptom management, diseases, treatments and health promotion. There is opportunity to identify other areas for specialist practice, within general nursing, which support holistic practice and enhance continuity of care. For example, areas such as ITU have not yet developed CNS roles. Access by nurses and patients/clients to consultation, education and specialist or advanced expertise is limited and the clinical career pathway of nurses is restricted. Development of such roles should be considered where there is an identified health service need, for example, a CNS role in critical care to enhance generalist practice which supports patients/clients following transfer from ITU to general wards. Such a CNS could provide a consultative role, lead and undertake audit, be an educator and carry his or her own caseload.

In the research for the *Agenda* document (National Council 2003) nurses described a role for the CNS which could reshape the way in which surgical care is provided. The CNS could run a nurse-led pre-admission clinic, provide in-patient care and support a nurse-led follow-up outpatient clinic. Links could be made directly from the surgical ward to the community thereby making the transfer from secondary to primary care seamless. With careful planning such roles would increase the continuity of care, provide specialist support for the defined clinical area and ensure that the patient is at the centre of a multidisciplinary approach to care delivery. The CNS in surgical care could provide a consultative role, lead and undertake audit, be an educator and carry his or her own caseload. There would be opportunities for the CNS to operate at a higher level of practice, making decisions at specialist practice level and where appropriate to develop nurse-led services. The opportunity for nurses to expand their practice as recommended by The *Report of the National Task Force on Medical Staffing* (DoHC 2003a) could therefore be realised.

5.2.2 Midwifery

Some midwives are of the view that specialisation may lead to fragmentation of care and that creating sub-specialities in midwifery in order to provide promotional opportunities is detrimental to professional development. It is likely that the current debate within midwifery practice regarding the future of midwifery and the need for specialism within midwifery care is affecting the current number of CMS posts identified within the service. Whilst in the short term this debate is an important matter for the midwifery profession, the long term future of specialism within midwifery practice needs to be addressed. Some midwives believe that the term 'enhanced practice' is more in keeping with the holistic philosophy of midwifery. Notwithstanding this valid perspective 31 CMS posts have been approved by the National Council. The titles include diabetic care, drugs liaison, ultrasound and foetal assessment, lactation specialist, urodynamics, neonatal, bereavement counselling and infection control. Other development opportunities could include mental health, needs of women with disability, domestic violence, health promotion, family planning and counselling.

5.2.3 Psychiatric nursing

The development of clinical specialist roles for psychiatric nursing has to date been innovative and responsive to health service need. There is much scope for development of additional regional roles. As the mental health services are currently under review, there is, and will be potential for expanding existing CNS roles and developing new ones within the structures of the services. Such developments need to take place in the context of patients/clients' need, service need and interdisciplinary working. The NMPDUs together with psychiatric nurse managers should examine opportunities for development. These could include anger management, child sexual abuse, GP liaison, anxiety management, mental health and addiction, schizophrenia, crisis intervention, psychiatric intensive care nursing, homeopathic interventions, bereavement counselling, dementia and forensic nursing. These are just some examples; new developments must reflect current health policy and always respond to patient/client need. Any developments must occur within an integrated service development framework and as part of interdisciplinary working.

5.2.4 Sick children's nursing

The geographical distribution of clinical nurse specialists for sick children's nursing (see table 3) is clearly disproportionate. There is a need to increase the number of CNSs in response to identified health service needs outside the major population centres. According to the *Agenda* (National Council 2003), there is room for development of posts in sick children nursing in areas such as pain management, neonatology, breastfeeding, community, adolescent care and health promotion, this must occur in tandem with assessment of service needs. There is scope for development of CNS posts both inside and outside of the ERHA region. A review of the needs outside the ERHA should be undertaken as some of the existing roles could be further developed. Areas for development could include colorectal nursing, neonatal care, adolescent care, anaesthesia, community paediatrics, challenging behaviour, health promotion, child development, transitional care co-ordinator, childhood obesity, sexual health and adolescent suicide.

5.2.5 Mental handicap nursing

The *Proposed Framework for the Development of Clinical Specialism and Advanced Practice in Mental Handicap Nursing* (DoHC 2002b) recommended that clinical specialisms be developed in accordance with a combination of client need, stages in the client's lifespan and negotiation between stakeholders, and that generic postgraduate/higher diploma programmes in mental handicap nursing be developed based on a model comprising core and specialist practice. While some CNS posts in mental handicap nursing certainly accord with the lifespan model (e.g., early intervention and care of the older person), many posts are concerned with behaviour management/challenging behaviour, activation and therapeutic programmes, and community nursing. Such posts have developed in response to an identified service need.

Development of specialist practice should be based on an approach that is evidence-based and best suits the needs of the client population. The total population with intellectual disabilities registered on the National Intellectual Disability Database is 25,448, of which 23,050 (90.6%) people were in receipt of specialised services in 2002 (Mulvany & Barron, 2003).

As this client population is not extensive, it may be appropriate for service providers to examine the use of regional or interagency posts. Demographic trends in the population with Intellectual Disability (ID) and predicted service needs should be examined when proposing developments in specialist mental handicap nursing.

The establishment of further CNS posts within ID services is highly desirable from the perspective of Registered Mental Handicap Nurses (RMHNs) and other nurses employed in these services. In establishing additional posts the prevailing ethos of individual service providers should be considered.

Given the size of the client population for mental handicap nurses, specialist posts may need to be developed on a regional basis. There are currently 105 CNS posts recorded on the National Council's database. Development of the CNS role in mental handicap nursing offers the potential to enhance community ID services.

However no evidence as to where RMHNs are employed is available, but the majority would appear to be employed in long term care services. Therefore client need within this area should be examined in order to determine the appropriate and substainable area of specialist practice.

5.2.6 Gerontological nursing

The development of the clinical nurse specialist role in the care of the older person has to date been slow. This is attributed to lack of funding and lack of provision for education (National Council 2003). To date, the National Council has approved thirteen CNS posts specific to care of the older person. Development of specialist posts must be a priority for service providers because the scope for nurse-led units is immense. Development of CNS posts in care of the older person could include stroke management, genito-urinary health, dementia care, mental health, diabetes, tissue viability and falls assessment. There could also be a CNS with an overall title in gerontological care.

5.3 Recommendations

Based on the conclusions and possibilities for the future direction, the following recommendations are outlined. The recommendations are broken down into recommendations for the role, recommendations for education and recommendations for service. The responsibility for implementing the recommendations lies at local, regional and national level.

5.3.1 Recommendations for the role

The research findings indicate that audit and research are the least well developed aspects of the core concepts of the CNS/CMS role. The use of audit to evaluate effectiveness of patient/client outcomes and to inform service planning is well documented. There is thus a need to ensure that CNSs/CMSs are prepared for, and supported in embracing this part of the role. Some CNSs/CMSs have had the opportunity to produce annual reports and thereby inform the service planning process. This activity needs to be further developed. Aspects of the role are continuously evolving in response to service need. The importance of the CNS/CMS in continuously educating other staff will help to maximise the potential of the role. Recommendations for the role will have implications for service provision. The director of nursing/midwifery is the key player in ensuring the recommendations are implemented at local level.

1 CNS/CMS post holders should audit the effectiveness of their role for service on a continuous basis.

2 CNS/CMS audit should inform the annual report of specialist services and should consequently inform the service planning process.

3 When new posts are established the job description must reflect the five core concepts as outlined by the National Council.

4 Reporting relationships should be explicit within the job description.

5 Where the research and audit concepts are under utilised, line managers must ensure that the CNS/CMS has access to continuing professional development and support for audit. Where possible this CPD should be provided from within the organisation's own resources.

6 The *Role Resource Pack* developed by the SEHB should be made available to all CNSs/CMSs.

7 The scope of the CNS/CMS role should continue to develop in line with evolving patient/client need.

8 CNSs/CMSs should be provided with performance review or feedback from their line manager. The *Role Resource Pack* may be a tool for facilitating this process.

9 The CNS/CMS should be supported to keep up to date with current relevant research to ensure evidence-based practice and research utilisation and should contribute to nursing research that is relevant to his/her area of practice.

10 CNSs/CMSs, in line with their professional responsibilities, should engage in continuing professional development.

11 The National Council should work closely with the NMPDUs and service providers to ensure consistency of titles without losing the flexibility for role development.

12 The National Council should revise the 'Aid to developing job descriptions/profiles for clinical nurs/midwife specialist posts'.

5.3.2 Recommendations for education

Post-registration education programmes must continue to develop to meet the needs of clinical specialist practice.

1 Third-level providers should ensure that curricula for preparation of nurses and midwives for specialist posts are underpinned by the five core concepts

2 The Centres for Nurse Education and service providers should support audit skills development at local level.

3 The third-level institutions, when establishing and reviewing post-registration programmes should implement the educational modular frameworks outlined by the *Report of the Commission on Nursing.*

4 Credit for prior learning should be given by third-level institutions when appropriate.

5 Where a CNS/CMS was approved in the immediate pathway every effort must be made to support the individual to undertake a higher/postgraduate diploma.

6 The National Council should review the educational preparation criteria for the intermediate pathway with a view to introducing the future pathway.

5.3.3 Recommendations for service

The development of CNS/CMS posts has, for the most part, been in response to local service need. A coherent, planned approach to future developments is required. This approach should be proactive, reflect health policy, population health and be responsive to service need.

1 The NMPDUs and the directors of nursing and midwifery should examine the possibility of developing CNS/CMS posts across care settings and services.

2 There should be planned expansion of the current scope and domain of CNS/CMS roles in line with service need and this expansion should be firmly rooted in government policy.

3 Where the clinical case-load does not warrant one part-time or full-time post, consideration should be given to posts on a wider local basis or regional level.

4 When a new CNS/CMS post is introduced to a service, there should be maximum collaboration with all the relevant stakeholders.

5 Where dual roles exist, formal structures should be put in place by the service provider to ensure clear delineation of both roles.

6 An annual review of service need for CNS/CMS posts should occur at local, regional and national level.

5.4 Future evaluation of service need for CNS/CMS posts

It is critical in the early years of the introduction of the specialist pathway that formal annual review of current specialist posts and identification of future needs occurs. This will be necessary to ensure that a critical mass of clinical specialists develops in response to service need. A needs assessment of skills and competencies is necessary at service level. The following outlines the process that should occur at local, regional and national levels; these processes should involve all the key stakeholders. When new roles and areas for development are identified third-level institutions and the Centres for Nurse Education need to be included in the process to ensure that the right competencies and skills will be available.

1) Needs assessment at service provider level involves the following steps:

1 Review of national and regional policy documents relevant to service area, for example the current cardiovascular strategy, *Building Healthier Hearts* (DoHC 1999), highlights increasing cardiovascular disease and the need for specialist nurses.

2 Review of local demographics and epidemiology, for example the MHB has the fastest ageing population (sources of local demographics and epidemiology include: public health departments, HIPE and case mix data, actionables and deliverables, *Quality and Fairness).*

3 Review of service need, for example large number of respiratory patients in A&E, may dictate the need for a CNS/CMS in this area.

4 Review of current specialist roles and their effectiveness through audit.

5 Where it is identified that there is a service need for new roles, examine national and international experience as to the effectiveness and appropriateness of the proposed roles.

6 If the service deems that a specialist post is necessary it is the responsibility of the local manager to use the service planning process to seek funding and work closely with the NMPDU regarding the parameters of the role.

2) Regional assessment by the NMPDUs of geographic spread of CNS/CMS posts relative to regional need involves the following steps:

1 Review of national and regional policy documents relevant to service area.

2 Review of regional demographic and epidemiological profile to identify whether new roles are necessary.

3 Review of current specialist roles relative to the area of practice and service needs.

4 Where it is identified that there is an apparent absence of specialist roles in response to an apparent service need, formal consultation with the service provider should occur.

5 If the service deems specialist post necessary, local manager should use service planning process to seek funding.

3) Annual assessment of geographic spread of CNS/CMS posts relative to national need involves the following steps:

1 Review of national policy documents relevant to service needs.

2 Review of national demographics and epidemiological profiles.

3 Review of current specialist roles relative to area of practice nationally, using the National Council database.

4 Where it is identified that there is an apparent absence of specialist roles in response to an apparent service need, formal consultation with the NMPDUs should occur – one meeting per year should be dedicated to this function.

5 If development of specialist posts is necessary, the NMPDUs should work at regional level to support this.

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‘It empowers nurses to develop outside the boundaries’

(DoN/DoM)

CNS/CMS Research Report

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APPENDICES

‘It created pathways for nurses’

(DoN/DoM)

CNS/CMS Research Report

Appendix 1
- the questionnaire

National Council for the
Professional Development
of Nursing and Midwifery

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

The National Council for the Professional Development of Nursing and Midwifery clinical nurse/midwife specialist research project questionnaire

Confidential

Q1. *In which of the following care settings do you work?*
(Please choose one only)

- Hospital ❑
- Community ❑
- Hospital & community ❑
- Other (please specify) ❑

_____

_____

_____

Q2. *Which of the following best describes your specialist area of practice?*
(Please choose one only)

- General ❑
- Psychiatry ❑
- Paediatrics ❑
- Care of the elderly ❑
- Midwifery ❑
- Mental handicap ❑
- Public health ❑
- Occupational health ❑
- General practice ❑
- Palliative care ❑
- Other (please specify) ❑

_____

_____

_____

Q3. *To whom do you report in relation to clinical matters?*
(Please choose one only)

- Clinical nurse/midwife manager 2 ❑
- Clinical nurse/midwife manager 3 ❑
- Assistant director of nursing/midwifery ❑
- Director of nursing/midwifery ❑
- Consultant ❑
- Non consultant hospital doctor ❑
- General practitioner ❑
- No-one ❑
- Other ❑

Q4. *To whom do you report in relation to professional matters?*

- Clinical nurse/midwife manager 2 ❑

- Clinical nurse/midwife manager 3 ❑
- Assistant director of nursing/midwifery ❑
- Director of nursing/midwifery ❑
- Consultant ❑
- Practice nurse facilitator ❑
- Director of nursing & midwifery planning & development unit ❑
- GP ❑
- Non consultant hospital doctor ❑
- Other (please specify) ❑

_____

_____

_____

Q5. Please score in order of importance the five core concepts of the CNS/CMS role as you perceive it,
1 = Most Important, 2 = Very important,
3 = Important, 4 = Not important, 5 = Least important

Core Concepts	***Rate 1-5***
Clinical	_____
Education & training	_____
Audit & research	_____
Patient advocacy	_____
Consultancy	_____

Q6. On a monthly average can you give an estimate of the percentage of time spent on the following areas?

Activity of Practice	***Time %***
Clinical	_____
Education & training	_____
Audit & research	_____
Patient advocacy	_____
Consultancy	_____
Other (please specify)	❑

_____

_____

_____

Q7. Please indicate to which age group you belong.

- 20-24 ❑
- 25-29 ❑
- 30-34 ❑
- 35-39 ❑
- 40-44 ❑
- 45-49 ❑
- 50-54 ❑
- 55-59 ❑
- 60-64 ❑

Q8. Please indicate which statement closely applies to you? (You may choose more than one option)

- Full time ❑
- Part time ❑
- Monday-Friday ❑
- Job share ❑
- 07:00 – 15:00 ❑
- 08:00 - 16:00 ❑
- 09:00 – 17:00 ❑
- Evening shifts ❑
- Week-end shifts ❑
- Night shifts ❑
- Other (please specify) ❑

_____

_____

_____

Q9. At work do you have access to the following? (You may choose more than one option)

	Yes	***No***
A computer	❑	❑
The internet	❑	❑
E-mail	❑	❑
Library services	❑	❑
A bleep	❑	❑
A voice mail service	❑	❑
An office	❑	❑
Secretarial support	❑	❑

Q10. How many hours per month do you spend on average with the following activities?

Activity	***Hours***
Multidisciplinary clinics	_____
Nurse/midwife led clinics*	_____
Direct clinical interventions with patients/clients	_____
Writing guidelines/policies	_____
Discussion with multidisciplinary team regarding patient/client care	_____
Discussion with nurses/midwives regarding patient/client care	_____

Education & training of patients/clients _____

Education & training of registered nurses/midwives _____

Education & training of student nurses/midwives _____

Education & training of multidisciplinary team _____

Clerical-making appointments, filing & finding notes _____

Nursing/midwifery research _____

Medical research (i.e. collecting data not used for nursing/midwifery purposes) _____

Continuing professional development (formal courses) _____

Continuing professional development (informal e.g. reflection, accessing library, clinical supervision etc) _____

Attending meetings _____

Travelling whilst at work _____

Telephone consultation with nurses/midwives _____

*Nurse/midwife led clinics are defined as care provided by nurses or midwives responsible for case management which includes, comprehensive patient/client assessment, clinical leadership and decision to discharge as appropriate.

Q11. Did you experience any of the following barriers with your role? (You may choose more than one option)

	Yes	*No*
Lack of multidisciplinary support	❑	❑
Lack of nursing support on professional issues	❑	❑
Lack of nursing support on clinical issues	❑	❑
Lack of other managerial support	❑	❑
A lack of understanding of the role of CNS/CMS by staff nurses	❑	❑
A lack of understanding of the role of CNS/CMS by clinical nurse/midwife manager 1,2,& 3	❑	❑
A lack of understanding of the role of CNS/CMS by yourself	❑	❑
A lack of understanding of the role of CNS/CMS by other health care professionals	❑	❑
Lack of access to continuing professional development	❑	❑
Lack of academic qualifications	❑	❑
Lack of resources to set up/develop the role	❑	❑
Lack of secretarial support	❑	❑
Lack of support from other CNSs/CMSs	❑	❑
Lack of clinical support	❑	❑

Other (please specify) ❑

_____

_____

_____

Q12. Are you the first person to fill this clinical nurse/midwife specialist post?

Yes ❑

No ❑

Don't know ❑

Q13. If you answered "no" to Q12 how many previous post holders were there? If 'yes' go to Q14

1 ❑

2 ❑

3 ❑

Don't know ❑

Q14. To whom can you refer patients/clients? Please tick (You may choose more than one option)

Dietician ❑

Physiotherapist ❑

Other CNSs/CMSs ❑

Occupational therapist ❑

Speech therapist ❑

Radiographer ❑

Community mental health nurse ❑

Public health nurse ❑

Social worker ❑

Psychologist ❑

Medical staff ❑

No-one ❑

Other (please specify) ❑

_____

_____

_____

Q15. From whom do you receive referrals? Please tick (You may choose more than one option)

Dietician ❑

Physiotherapist ❑

Other CNSs/CMSs ❑

Occupational therapist ❑

Speech therapist ❑

Radiographer ❑

Public health nurse ❑

Community mental health nurse ❑
Social worker ❑
Psychologist ❑
Medical staff ❑
Staff nurses ❑
CNM 1, 2 or 3 ❑
Self referrals from patients/clients/relatives ❑
No-one ❑
Other (please specify) ❑

Q16. What type of feedback do you receive? (You may choose more than one option)

Do not receive feedback at all ❑
Clinical supervision ❑
Mentorship ❑
Team meetings ❑
Formal performance review ❑
Informal ❑
Ad hoc performance review ❑
Other (please specify) ❑

Q17. If you do receive feedback, from whom do you receive it? (You may choose more than one option)

Director of nursing/midwifery ❑
Assistant director of nursing/midwifery ❑
Clinical nurse/midwife manager 2 ❑
Clinical nurse/midwife manager 3 ❑
Staff nurses/staff midwives ❑
Patients/clients ❑
Families of patients/clients ❑
Medical staff ❑
Members of the mutlidisciplinary team ❑
Other (please specify) ❑

Q18. Do you have a personal development plan?

Yes ❑
No ❑
Don't know ❑

Q19. Can you identify the factors that helped you develop your role? Please tick (You may choose more than one option)

Own communication skills ❑
Clinical experience ❑
Acceptance of role by nursing/midwifery colleagues ❑
Acceptance of role by multidisciplinary team (other than medical staff) ❑
Acceptance of role by medical staff ❑
Good organisational structure ❑
Understanding of role by yourself ❑
Support from other CNSs/CMSs ❑
Good introduction/orientation ❑
Academic qualifications ❑
Continuing professional development ❑
Support from management ❑
Personal motivation ❑
Networking with nursing/midwife colleagues ❑
Other (please specify) ❑

Q20. Do you write an annual report on your activities?

Yes ❑
No ❑
Don't know ❑

Q21. If you answered yes to Q20 to whom do you send it? Please tick

Clinical nurse manager ❑
Director of nursing ❑
Assistant director of nursing ❑
Chief executive officer ❑
Medical staff ❑
Other (please specify) ❑

Q22. Does your organisation have a strategic vision for the development of the specialist service that you provide?

Yes ❑
No ❑
Don't know ❑

Q23. Do you contribute to your organisation's service plan?

Yes ❑
No ❑
Don't know ❑

Q24. Have you ever measured the following performance outcomes for your patients/clients?
(You may choose more than one option)

	Yes	*No*
Numbers seen	❑	❑
Waiting times	❑	❑
Effectiveness of interventions	❑	❑
Referrals made	❑	❑
Referrals received	❑	❑
Telephone consultations	❑	❑
Patient/client satisfaction	❑	❑
Quality of life indicators	❑	❑
Reduction in hospital admissions	❑	❑
Reduction in visits to the emergency department	❑	❑
Reduction in attendance to the general practitioner	❑	❑
Other (please specify)	❑	

Q25. If you measure performance outcomes, do you change your clinical practice as a result

Yes ❑
No ❑
Don't know ❑

Please give one example

Q26. Are you: ***Male*** ❑ ***Female*** ❑

Q27. What post-graduate education have you completed? Please give the full title and year of any course:

Certificate(s) in a specialised area

Certificate(s) (other) Please specify

Diploma(s)Please specify

Primary Degree (Please specify)

Postgraduate/ Higher Diploma

Postgraduate Masters' degree (Please specify)

PhD

Q28. Are there any other comments you would like to make about your role/post?

Appendix 2 - focus groups terms of reference and questions

Clinical Nurse/Midwife Manager's Focus Group

Terms of reference

- To explore the Clinical Nurse/Midwife Managers' perspective on the role of the Clinical Nurse Specialist.
- To explore the Clinical Nurse/Midwife Managers'understanding of the parameters of the role.
- To enable the Clinical Nurse/Midwife Managers'to discuss their views about the impact of the role.

Key questions for focus groups (CNMs/CMMs)

Please fill in answers under each question & where possible include verbatim quotes

- Number of participants _____
- Can you comment on the general atmosphere of the session?

- Any other observations of interest?

1. Can you identify the key functions of the role? (Probe – are there any essential personal qualities that you think are needed for this?)

2. Do you think the introduction of the role has been successful? (If not why not, if yes, can you identify why?)

3. Do you think that the CNS/CMS makes a difference to the quality of patient care? (If not, why not, if yes how is this measured/audited)

4. Do you think that the CNS/CMS contributes effectively to the education of staff nurses/midwives?

5. Do you think that the CNS/CMS operates at the level as outlined in the five core concepts?

6. Do you think the role of the CNS/CMS has been worthwhile? (If not, why not, if so why?)

Clinical Nurse/Midwife Specialist Focus Group

Terms of reference

- To identify the key components of the role of the clinical nurse/midwife specialist.
- To identify the barriers to the development of the role
- To identify what has been helpful in the development of the role.
- To identify if the clinical nurse/midwife specialists feel that they make a difference to the quality of care of their patient/client group
- To establish if clinical nurse/midwife specialist's evaluate their work and if so how and by what method

Key questions for focus groups (CNS/CMS)

Please fill in answers under each question & where possible include verbatim quotes.

- Number of participants _____
- Can you comment on the general atmosphere of the session?

- Any other observations of interest?

1. Can you identify the key functions of your role? (Probe – are there any essential personal qualities that you need for this?)

2. Can you reflect on what has been helpful in the development of your role? (Probe – were there any obstacles?)

3. What do you think would have prepared you more fully for the role? (Probe - can you be specific in relation to knowledge and skills?)

4. Are there some aspects of your role that you feel you would like to develop further? (Probe - is the impetus for this development personal or an expectation of the organisation?)

5. Do you feel that as a CNS/CMS you make a difference to the quality of care patients and families receive? (Probe - in what way can you measure this?)

6. Can you now outline what makes you a CNS/CMS? (Probe- what do you do that is different from experienced ward staff?)

Directors of Nursing/Midwife Focus Group

Terms of reference

- To explore the Directors of Nursing/Midwifery understanding of the role
- To enable the Director of Nursing/Midwifery to discuss their views about the impact of the role.
- To identify if the Director of Nursing/Midwifery expect audits/annual reports/feedback from the CNS/CMS

Key questions for focus groups (DoNs/DoMs)

Please fill in answers under each question & where possible include verbatim quotes.

- Number of participants _____
- Can you comment on the general atmosphere of the session?

- Any other observations of interest?

1. Can you identify the key functions of the role? (Probe – are there any essential personal qualities that you think are needed for this?)

2. Do you think the introduction of the role has been successful? (If not why not, if yes, can you identify why?)

3. Do you think that the CNS/CMS makes a difference to the quality of patient care? (If not, why not, if yes how is this measured/audited?)

4. Do you think that the CNS/CMS contributes effectively to the education of staff nurses/midwives?

5. Do you think that the CNS/CMS operates at the level as outlined in the five core concepts?

6. Do you think the role of the CNS/CMS has been worthwhile? (If not, why not, if so why?)

Staff Nurses/Midwives Focus Group

Terms of reference

- To explore the staff nurses/midwives' perspective of the role of the clinical nurse/midwife specialist.
- To explore the staff nurses/midwives' understanding of the role of the clinical nurse/midwife specialist.
- To explore the staff nurses/midwives' views on the contribution the clinical nurse/midwife specialist makes to their own role.

Key questions for focus groups (Staff Nurses/Midwives)

- Number of participants _____
- Can you comment on the general atmosphere of the session?

- Any other observations of interest

1. Can you identify the key functions of the role? (Probe – are there any essential personal qualities that you think are needed for this?)

2. Do you think the introduction of the role has been successful? (If not why not, if yes, can you identify why?)

3. Do you think that the CNS/CMS makes a difference to the quality of patient care? (If not, why not, if yes how is this measured/audited)

4. Do you think that the CNS/CMS operates at the level as outlined in the five core concepts?

5. Do you think the role of the CNS/CMS has been worthwhile? (If not, why not, if so why?)

6. Can you identify how the CNS/CMS benefits you most in the clinical setting?

7. Can you identify areas where you think the CNS/CMS could help you in your role?

Appendix 3
- titles of CNS/CMS posts

TITLE	NUMBER OF POSTS
Addiction Counselling	18
Addiction Counsellor	24
Adults with Autistic Spectrum Disorder	1
Affective Disorders	4
AIDS	1
Airways/Tracheostomy	1
Alcohol Addiction Counselling	1
Alcohol Counselling	2
Alternative and Augmentative Communication	2
Anaesthetic Support	1
Apheresis	2
Asthma	4
Asylum Seeker Health Assessment	1
Attention Deficit/Hyperactive Disorder	
Hyperactive Disorder	1
Autism	2
Autism Hyperactive Disorder	1
Autistic Spectrum Disorders	1
Autotransfusion	3
Behaviour Management	6
Behaviour Nurse Challenging Behaviour Unit	1
Behaviour Nurse Psychotherapist	1
Behaviour Nurse Therapist	2
Behaviour Therapy	23
Behavioural Nurse Psychotherapist	1
Behavioural Psychotherapy	4
Behavioural Therapist	2
Behavioural Therapy	1
Bereavement Counselling	3
Bone Bank Co-ordinator	3

TITLE	NUMBER OF POSTS
Bone Marrow Registry Co-ordination	1
Bone Marrow Transplant Co-ordinator	1
Bone Tumour	1
Brainwave Community, Epilepsy	1
Breast Care	21
Breastfeeding	1
Cancer Co-ordinator	3
CAPD	2
Cardiac Disease	1
Cardiac Disease Management	1
Cardiac Liaison	2
Cardiac Rehabilitation	25
Cardiology	9
Cardio-Pulmonary Rescuscitation - Neonatal	1
Cardio-Pulmonary Resuscitation	11
Care of the Elderly - Learning Disabilities	1
Challenging Behaviour	3
Chemotherapy	2
Chest Pain	4
Child & Adolescent Psychiatry	3
Child & Adolescent Psychiatry Liaison	1
Child & Family Counselling	1
Child Psychiatry	1
Cognitive Behaviour Therapy	1
Cognitive Behavioural Psychotherapist	1
Cognitive Behavioural Therapy	2
Coloproctology	2
Colorectal	1
Colposcopy	1
Community Child & Adolescent Psychiatry	36

TITLE	NUMBER OF POSTS
Community Mental Handicap	21
Community Mental Health	19
Community Mental Health Nurse	198
Community Psychiatry of Old Age	10
Community Rehabilitation of the Older Person	1
Complementary Therapies	1
Complementary Therapy	4
Complementary/Supportive Therapies	1
Continence Advice	4
Continence Advisor	1
Continence Management Elderly Care Services	3
Continence Promotion	7
Continence Promotion in Learning Disabilities	2
Continence/Urodynamics	1
Counselling	9
Counsellor	3
Creative, Diversional & Recreational Activation	10
Crisis Intervention	3
Crisis Intervention Liaison	1
Cystic Fibrosis	13
Cystic Fibrosis Liaison	2
Deliberate Self-Harm	1
Dementia	2
Dermatology	16
Diabetes	48
Diabetes Liaison	1
Diabetes Nurse Education	1
Diabetic Care	1
Diversional & Recreational Activation	1
Diversional & Recreational Activation for the Older Person	1
Diversional Therapy	2
Divisional Therapy/Health Promotion	1
Drug Court	1
Drugs Liaison	3

TITLE	NUMBER OF POSTS
Dyspnoea	1
Ear Nose and Throat	1
Early Intervention	15
Early Intervention - Autism	1
Early Intervention - Disabilities	2
Eating Disorder	2
Elderly Assessment	1
Elderly Care	1
Emergency Practice	3
Endocrine Liaison	1
Endocrine Nurse Specialist	1
Enduring Mental Illness	1
ENT	1
ENT/Head and Neck	1
Epidermolysis Bullosa Liaison	1
Epilepsy	3
Epilepsy & Health Promotion	1
Falls / Osteoporosis	1
Family & Marital Therapist	2
Family Therapist	9
Family Therapy	7
Family Therapy Nurse	1
Foetal Assessment	5
Foetal Assessment & Ultrasonography	1
Functional Gerontology	1
Gastroenterology	2
General Practice	189
Gerontological Assessment	1
Gerontological Rehabilitation	1
Haematology	7
Haemophilia	3
Haemophilia & Related Disorders	1
Haemovigilance	13
Head & Neck Oncology	2

TITLE	NUMBER OF POSTS
Health & Well-Being	1
Health Advice	2
Health Promotion	1
Health Promotion & Intervention	4
Health Promotion & Intervention - Intellectual Disability Nursing	1
Heart Failure	6
Hepatitis C Research	2
Hepatology	7
Hepatology, Hepatitis C	1
HIV/AIDS Liaison	2
Home based treatment - acute psychiatry	6
Home Therapy Immunology	1
Ilizarov Method	2
Infection Control	45
Infection Control/Occupational Health	1
Integrative Counselling	3
Interventional Radiology	1
Invasive Cardiology	1
Joint Replacement	1
Lactation	9
Laser Therapy	1
Lithotripsy	1
Liver Liaison	1
Liver Recipient Co-ordinator	2
Lung Cancer	1
Lung Cancer Nursing	1
Lung Transplant Co-ordinator	1
Lymphodema	1
Male Genito - Urinary Cancer	1
Mammography	1
Mental Health Education	1
Mental Health Promotion	1
Mental Health Promotion & Intervention	1
Metabolic Disorder	1

TITLE	NUMBER OF POSTS
Migrane/Headache	1
Minor Injuries	3
Mobility & Therapeutic Programme	1
Mobility and Therapeutic Interventions	1
Motor Neurone Disease Liaison	1
Multiple Sclerosis	3
Multiple Sclerosis/Neuro-Immunology	1
Neonatal	1
Neonatal & Paediatric Neurology	1
Neonatal Resuscitation	1
Nephrology	2
Neurology	5
Neurology Liaison	1
Nutrition	2
Occupational Health	28
Older People Nursing	1
Older Person - Learning Disabilities	1
Oncology	32
Oncology Liaison	10
Oncology/Breast Care	3
Oncology/Palliative Care	1
Ophthalmology	9
Orthopaedic Casting & Splinting	6
Orthopaedic Liaison	1
Osteoporosis	1
Paediatric Casting	1
Paediatric Diabetes	2
Paediatric Haemodialysis	1
Paediatric Liaison	2
Paediatric Oncology	1
Paediatric Oncology Liaison	2
Paediatric Opthalmology	1
Paediatric Orthopaedics	1
Paediatric Pain	1

TITLE	NUMBER OF POSTS
Paediatric Renal	1
Pain Control	6
Pain Management	5
Pain Medicine	1
Palliative Care	31
Palliative Care - Learning Disabilities	1
Palliative Home Care	123
Parent Educator	1
Parkinson's Disease/Aspen	1
Peri-Anaesthesia	1
Personal Development Programmes	3
Physical & Mobility Habilitation	1
Physical Disability	1
Pre-school Learning Disability & Autism	1
Primary Care (Mental Health)	1
Psychiatric Consultation Liaison	2
Rehabilitation Care of the Older Person	1
Renal	2
Reproductive Health Care	2
Respiratory	23
Respiratory/Asthma	1
Respiratory Care	3
Respiratory Care, Sleep Disorders	1
Respiratory Medicine	1
Respiratory Nursing	1
Resuscitation	5
Rheumatology	6
School children with special needs	1
Senior Health Adviser	1
Sensory Integration & Therapeutic Programmes	1
Sexual Health	1
Sexual Health Promotion	1
Sexual Health/AIDS Liaison	1
Smoking Cessation	4
Smoking Cessation/Health Promotion	1
Social & Vocational Rehabilitation	1
Spinal Cord Injury - Liaison Nursing Service	1
Stoma and Breast Care	2
Stoma Care	17
Stomatherapy	2
Stress Management/Bio-Feedback	1
Stroke Care	3
Substance Misuse	1
Supported Living	1
Surgical Liaison	1
Systemic Family Therapy	2
Therapeutic Apheresis	1
Therapeutic Programmes	13
Therapies, Mental Health Care for Older People	1
Tissue Viability	11
Transfusion	1
Transfusion/Haemovigilance	1
Transfusion Surveillance	11
Transplant Liaison	1
Trauma and Minor Injuries	1
Ultrasound	3
Ultrasound and Foetal Assessment	3
Urodynamics	6
Urodynamics and Continence	1
Urodynamics/Rectal Manometry	1
Urology	7
Vocational Rehabilitation	5
Wound Care	5
Wound Care/Tissue Viability	1