Evolution of the Clinical Nurse Specialist Role and Practice in the United States

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INTRODUCTION

Beginning in the 1940s, much has been written about the need for a clinical expert in nursing practice and the clinical nurse specialist (CNS) role. With decades of literature available, it is possible to trace the CNS role and its legacy of leadership for advancing the practice of nursing. The purpose of this chapter is to understand the historical development of the CNS role, the rationale for creation of the role, educational and social challenges, and past and current conceptualization of practice. The review of the evolution of the CNS provides a basis for envisioning opportunities and challenges for the future of the CNS role and practice.

■ EARLY HISTORICAL ROOTS

Evidence indicates that the idea for a clinical expert in nursing emerged in the 1940s. In the first textbook written for CNSs, *The Clinical Nurse Specialist: Interpretations* by Riehl and McVay (1973), it was suggested that the 1923 Winslow–Goldmark Committee report on nursing education, sponsored by the Rockefeller Foundation, set in motion events creating a need for clinical experts in nursing practice. Also called *The Study of Nursing and Nursing Education in the United States*, the report noted inadequacies in hospital nursing education and identified as a central problem the extended hours of service worked by students in apprenticeship hospital training programs. A poor educational option, hospital training was made worse by lack of curricular standards, insufficient

pedagogical knowledge among faculty, and inadequate instruction in the application of science and theory to practice (Bullough & Bullough, 1979; Ellis & Hartley, 2004; McHenry, 1983). As a result of these findings, nursing placed great emphasis on roles of teaching and administration in an effort to improve academic curricula, the scientific quality of nursing content, and clinical education experiences. Evidence of a focus on educators and clinical supervisors can be seen in the preface to Wolf's (1947) textbook for nurses:

The never-ending task of improving the quality of nursing practice falls squarely upon the shoulders of the teaching personnel in schools of nursing and in public health nursing agencies. Those who are responsible for planning and providing the classroom and field practice experiences for nurse students are constantly striving to enrich these learning experiences and keep them in line with newer developments in the broad field of public health and preventative medicine. (p. v)

The subsequent release of Esther Lucile Brown's *Nursing for the Future* (E. L. Brown, 1948) further reinforced the need to improve nursing education. Called the “*Brown report*,” it also criticized hospital training programs while strongly advocating for collegiate-level nursing education. Less well noted in the report was Brown's observation that the pendulum had swung too far and resulted in an overemphasis on teaching and administration at the expense of patient care. Brown called for increasing educational efforts to help students acquire

clinical knowledge and develop the expert skills necessary for supporting direct care of patients, including persons both sick and well. Nursing education needed to shift focus from an emphasis on doing of tasks to teaching scientific knowledge and creating opportunities for students to apply knowledge in the care of patients. Nurses, Brown argued, needed to possess discriminative judgment and demonstrate clinical leadership. In particular, she noted that nurses needed to be able to (a) make a unique contribution to the prevention and treatment of illness; (b) improve nursing skills and develop new nursing skills; (c) teach and supervise other nurses and ancillary workers; and (d) cooperate with other professions in planning for health at community, state, national, and international levels (Allen, Koos, Bradley, & Wolf, 1948).

In 1956, the National League for Nursing (NLN) sponsored the National Working Conference in Williamsburg, Virginia, to discuss the need for a psychiatric clinical expert (NLN, 1958). With the prevailing emphasis on programs to train teachers and administrators, conference participants determined that a new role would need to be created to fill the gap in clinical expertise. The purpose of this new role, labeled “*clinical specialist*,” was “to bring about advances in the art and science of psychiatric nursing and to promote the application of new knowledge and methods in the care of patients” (NLN, 1958/1973, p. 8). The new specialist role was to be prepared at the graduate degree level. The final conference report included a description of clinical competencies for the new role and basic elements of a graduate-level curriculum.

Concerns continued to be expressed about the lack of attention to developing clinical nursing experts. Appointed the first dean of the Graduate School of Nursing at New York Medical College, Frances Reiter became a leading voice for developing educational programs to prepare advanced clinical experts in many different specialty areas (Hiestand, 2006). Reiter’s 1961 essay *Improvement in Nursing Practice* criticized hospital nursing service departments for devaluing direct patient care provided by the graduate nurses (*graduate nurse* being the term used for what are now called registered nurses). She asserted that hospital nursing services were controlled by nurses who were not clinically skilled but rather were highly influenced by policies of hospital administration (Reiter, 1961/1973). In addressing the American Nurses Association (ANA), she forecast a preferred future:

I believe that someday an Academy of Nursing will be established. Membership in this academy will be an honorable one. The members will be selected from those practitioners who are clinical nursing specialists. Because of their values in practice, their clinical knowledge and their judgment, this corps of practitioners will give us professional leadership in advancing the excellence of our practice. (p. 18)

As a dean, Reiter’s goal was to prepare a new kind of expert clinical nurse. In 1948, she had chaired the second of five studies funded by the W. K. Kellogg Foundation to develop teaching and learning experiences for nurses, the *Study of Advanced Clinical Nursing Education* (Hiestand, 2006). In 1966, she again called for a renewed emphasis on clinical practice and described an expert nurse-clinician. This expert nurse-clinician was to be a master practitioner for all dimensions of nursing practice. The expert nurse-clinician would provide both basic and technical care while using discriminative judgment in “assessing problems” [diagnosis], “determining care priorities,” and “selecting nursing measures” [interventions] to achieve “therapeutic objectives” [outcomes]. To achieve this level of practice, the expert nurse-clinician would need knowledge of basic sciences and principles underlying care and would use this knowledge to promote quality of care and remove system-level barriers to care delivery. As she expressed it, the expert nurse-clinician would be “committed to ‘hacking’ her way down through the personnel pyramid so that her professional knowledge and judgment are exerted on behalf of every patient” (Reiter, 1966, p. 9). Further, the expert nurse-clinician’s motivation, judgment, and expert skills were envisioned to benefit patients both directly and indirectly because the visible expertise of this clinician was expected to provide leadership for the nursing staff in the delivery of patient care.

In summary, the early history of the CNS was a vision of a clinically expert role in nursing in response to a growing need for knowledgeable and skilled nurses to provide direct care and to lead the delivery of nursing care by others. An expert clinical nurse was expected to be grounded in theory and scientific evidence, possess high-level clinical skill, and be able to advance nursing care techniques, mentor nursing staff, assure excellence and quality, collaborate with other care providers, and remove system barriers to care delivery. This vision of the clinical expert created the CNS role.

■ THE CNS ROLE TAKES SHAPE

“Role” is defined as a set of expected functions of a person and is characterized by a pattern of behavior in a given social context. CNS is a functional role in nursing actualized through a set of professional practice competencies. These competencies are learned through formal academic preparation at the graduate level. The commitment to graduate education, education that included a practice component, was championed as the best educational approach. In 1971, Plawecki wrote:

Through formal, higher education the nurse gains deeper knowledge into theories and principles as they pertain to nursing. Through practice the nurse gains insight into the applicability of the principles in the care of patients. The combination makes the clinical nurse specialist. (p. 49)

Multiple articles beginning in the 1960s helped to define and establish the core practice competencies of the CNS role. From the combined academic and practice perspective as both assistant dean for clinical nursing, Case Western Reserve University, and associate administrator for nursing, University Hospitals of Cleveland, MacPhail (1971) summarized much of the prevailing thinking about the expectation for the clinical expert role. The competencies of the new clinical expert role were expected to include synthesizing physical, biological, and behavioral sciences for application to practice; serving as role model for staff; assessing the care given by other staff and identifying needs for improvement; providing consultation in an area of specialization; teaching both patients and personnel; understanding group dynamics; demonstrating high-level interpersonal skills; working effectively with the healthcare team; serving as change agent; fostering inquiry; identifying problems for investigation; participating in research; and fostering initiative, resourcefulness, and creativity in improving patient outcomes. Table 1.1 summarizes a selected sample of the CNS role descriptions and core competencies identified in the literature of the 1960s and 1970s. Not until 1998 were the common functional role competencies of CNS practice enunciated (National Association of Clinical Nurse Specialists [NACNS], 1998). These first-ever CNS core practice competencies, issued by a professional organization, relied heavily on a review of the literature and the job descriptions of practicing CNSs (Baldwin et al., 2007). The common agreed-upon

expectations summarized by MacPhail were evident in the job descriptions of contemporary CNSs, and most of the early expectations were incorporated into the first set of competencies. Subsequent iterations of CNS role competencies (NACNS, 2004, 2008, 2019) have included these same competencies, making for remarkable consistency in the expectations of the CNS role across the past 50 years.

■ ADVANCED SPECIALTY PRACTICE

At the same time the CNS role was being conceptualized, specialization in healthcare was evolving and creeping into nursing practice. In 1949, the idea of specialization was introduced at a conference of graduate program directors convened at the University of Minnesota (Sills, 1983). In 1967, Little noted that specialization in nursing had moved well beyond the usual fields of public health and hospital nursing and the usual functions of teaching and supervision. Specialization was emerging in clinical areas based on body systems, age, type of illness, and scientific content areas and, with reluctance, Little (1967) conceded that specialization in nursing had indeed arrived.

The idea of specialty-focused practice for nurses was discussed in the first issue of the *American Journal of Nursing* in an article by DeWitt (1900). DeWitt's comments were prompted by the turn-of-the-century emergence of specialties in medicine and healthcare practices. Physicians were becoming more focused on medical practice; dentistry and pharmacology were becoming autonomous specialty practices and no longer services provided by the physician. DeWitt stated a belief that all nurses should first be trained as generalists and, while she saw no immediate need for specialists, conceded that a nurse could pursue a specialty out of personal interest. Should a nurse choose a specialty, she (all nurses were referred to using the feminine pronoun in most early nursing literature) should engage in additional and continued studies in the specialty area and likewise should keep abreast of advances in science in the specialty.

The importance of specialization in nursing continued to be debated. In a landmark paper, Peplau (1965) discussed the nature of specialties in clinical nursing practice and noted three social trends that gave rise to specialty practice: (a) increasing knowledge about a phenomenon, (b) new technology emerging from new knowledge, and (c) emerging areas of public need. Specialization was defined

TABLE 1.1 SUMMARY OF SELECTED EARLY PUBLICATIONS ABOUT CNS ROLE AND COMPETENCIES DESCRIPTIONS

Descriptions of CNS Role	Descriptions of CNS Practice Competencies	Reference
Independent provider for continuity of care; clinical leader for nursing staff	Explore and study (research) ways to improve patient care; understand patient needs; apply theory to practice; observe and report results objectively	Crawford (1964)
Independent clinician; model of expertness representing advanced or newly developing practices	Clinical expert; develop innovations in practice based on emerging knowledge; interprofessional collaboration	Peplau (1965)
Expert nurse in direct care of patients; working with other nurses to improve performance	Work with difficult patients; analyze needs; problem-solve; interpret nursing care principles to nursing personnel	Anderson (1966)
Expert professional practitioner; assumes direct and continuing responsibility for nursing care of patients	High levels of knowledge and cognitive ability demonstrated in practice; skilled decision-maker; high level of ability in identifying patient problems and selecting intervention	Johnson, Wilcox, and Moidel (1968)
Professional nurse with advanced knowledge and competence in nursing	Activities include many things: teaching, providing leadership in planning patient care, or exclusively practicing direct nursing care	Towner (1968)
A nurse who practices nursing by applying specific, relevant theories and knowledge from nursing and allied disciplines to persons requiring specialized nursing services	Deliver expert care; guide allied nursing personnel as teacher and model; innovate or initiate change; contribute to nursing knowledge through research and practice; coordinate activities with persons in allied disciplines; consult with those requiring clinical nursing judgment and knowledge	Berlinger (1969)
Expert nurse with definite responsibility for influencing patient care	Uses a theoretical framework for change—one that allows for description and analysis of problems for organizing and interpreting what the nurse perceives; brings about through conscious, deliberate, and collaborative effort the improvement of patient care	Gorden (1969)
Nurse with special preparation through education and experience to serve as expert practitioner and consultant	Practitioner providing direct care; consultant directing, guiding, and assisting nursing staff to provide nursing care to patients; educator providing staff development to improve clinical competence; collaborates in initiating and facilitating patient care programs with health team members	Kurihara (1973)

CNS, clinical nurse specialist.

as a division or partitioning of a more general area of practice along some logical lines. Specialization involved a narrowing and deepening of focus or combining aspects of different areas of knowledge and practice competencies with a simultaneous narrowing and deepening of focus (Peplau, 1965). Specialties were acknowledged as the inevitable result of new knowledge and demands of the public for new services (Smoyak, 1976). As such, specialties are adaptations arising in response to scientific and

technological discoveries and continuously evolving to meet health concerns in a society. Specialties evolve and are refined, promoted, and molded; become outdated; and are discarded. Most importantly, specialties are determined by society's needs for nursing care. Specialization gives the nursing profession the ability to address the public's need for services by expanding and contracting clinical practice. Areas for specialty practice suggested by Peplau in 1965, summarized in Table 1.2, were

TABLE 1.2 EARLY EXEMPLAR AREAS OF SPECIALIZATION SUGGESTED BY PEPLAU (1965)

Areas of Specialization	Examples
Areas of practice	General hospitals, psychiatric hospitals, tuberculosis hospitals, mental retardation centers, industry
Organs and body systems	Cardiac, renal, and cardiac surgery
Age of client	Infant, premature infant, child, juvenile, adolescent, adult, and geriatric
Degree of illness	Progressive care, acute illness, convalescent care, and chronic illness services
Length of illness	Short term (ambulatory), intermediate, and long term
Fields of knowledge	Knowledge gives rise to new terminology; for example, nuclear nursing, interpersonal nursing, electronics nursing, and space nursing
Work functions role of staff nurse	Mother-surrogate nurse, expert technical nurse, health teacher, nurse counselor
Professional goal	Rehabilitation nursing, prevention nursing, curative nursing, ameliorative nursing
Clinical services	Medical, surgical, maternal, pediatric, psychiatric mental health

Source: From Peplau, H. (1965). Specialization in professional nursing. *Nursing Science*, 3, 268–287.

intended as examples and expressly considered as neither exhaustive nor static, only suggestions based on observation about nursing practice at the time. The fluidity of nursing practice is evident as some specialties evolved and remain while others did not mature or faded away.

Creating specialties required thoughtful consideration and attention to possible problems. Peplau (1965) offered two cautions where specialty practice was concerned. The first caution addressed the growing complexity of healthcare delivery, particularly in post–World War II hospitals, which saw the emergence of multiple types of care providers. She noted that “nurses must pinpoint intersecting, overlapping, and identical functions and activities which they share with other professional disciplines. And nurses must identify their unique nursing functions” (Peplau, 1965, p. 276). Peplau’s caution echoes E. L. Brown’s (1948) earlier recommendation that nursing identify its unique contribution to patient care anchored in nursing knowledge and skill. Peplau was concerned that nurses not gravitate into practice areas and specialties where they would merely be duplicating the services offered by others. Peplau’s second caution addressed keeping specialization efforts focused on developing “*clinical experts*” in patient care. Experts in the delivery of patient care services, such as care coordinators or others with responsibilities for supervisory or administrative duties, were different from, and should not be substituted for, clinical experts in specialty patient care.

Specialties ebb and flow, adapting to the availability of knowledge, advances in technology, and public health demands. Today, due to advances in antibiotic therapies, nurses specializing in tuberculosis hospital care are not needed. Similarly, Peplau could not have foreseen a need for CNSs in AIDS, a disease that was only described in the 1980s. It has been, and remains, the responsibility of CNSs, grounded in nursing theory, science, and use of evidence in practice, to interpret the public’s need for nursing services and bring nursing expertise to new and emerging specialties for the public good.

Defining Specialty Practice

Specialization eventually was recognized as a mark of advancement for the profession (ANA, 1980; Snyder, 1990). In 1980, ANA defined specialization in nursing as

a narrowed focus on a part of the whole field of nursing involving the application of [a] broad range of theories to selected phenomena within the domain of nursing in order to secure depth of understanding as a basis for advances in nursing practice. (p. 21)

At present, specialty is defined by the ANA (2010) as a delimited or concentrated area of expert clinical practice with focused knowledge and competencies. The Accreditation Board for Specialty Nursing Certification (ABSNC) defined a

specialty as having the characteristics of (a) being a distinct and well-defined field of nursing practice that subscribes to the overall purpose and function of nursing; (b) being distinct from other nursing specialties; (c) being national in scope; and (d) addressing an identified need for the specialty and for the specialty nurses who devote most of their practice to the specialty. In addition, a specialty should have a research-based body of knowledge related to the nursing specialty with mechanisms established for the support, review, and dissemination of research and knowledge in the specialty. Activities within the specialty contribute to the advancement of nursing science within the specialty (ABSNC, 2019; Burns & Welk, 1997).

The method for determining specialties in nursing has developed along with the total number of specialties. Styles (1990) advocated for a single, central authority designated to recognize specialties and specialty standards to give nursing a source of authority for its specialties. Without a central authority in nursing, Styles argued, specialties would be self-declared and self-ordained, susceptible to internal fluctuations and disorganization, and vulnerable to outside forces competing for power and resources. In contrast, Snyder (1990) noted that because nursing is continuously developing its body of knowledge and is also part of a dynamic health-care system and society, any organizing framework for specialization in nursing would be, of necessity, continuously evolving and at the same time continuously out of date.

At present, many CNSs practice in well-established specialties attached to large professional organizations, several of which have created scope and standards for CNS practice in the specialty, such as the American Association of Colleges of Nursing (AACN) *Scope and Standards of Professional Performance for Acute Care Clinical Nurse Specialist* (American Association of Critical Care Nurses, 2014). For established specialties, Styles's vision of a central authority that recognizes and regulates the specialty is a good fit. However, for smaller, emerging specialties, Snyder's arguments are a better fit. ABSNC's (2019) criterion for determining a specialty includes role delineation and job analysis data as evidence of a unique role for providers practicing in the specialty. Small and emerging specialties often lack the number of providers to conduct role delineation studies. Further, role delineation studies may simply codify existing practice and not provide the insights necessary for advancing practice in new directions as determined by the public need for nursing care. The inability

to be recognized in a specialty is an ongoing concern for CNSs who, as practice leaders, historically have been, and likely will continue to serve, on the forefront of newly emerging specialties. In 2004, the NACNS stated that CNS practice specialties could be identified as population, type of problem, setting, type of care, or disease. The fluidity of specialty practice can be seen by reviewing Table 1.2, where many of the specialties proposed by Peplau in 1965 are no longer relevant, made obsolete by changes in medical treatment, technology, and economics, changes that have in turn given rise to newer and different specialties.

Evolving CNS Specialty Practice

There is a dearth of information describing the process for evolving CNS and other advanced practice nursing roles. Hanson and Hamric (2003) proposed a model for evolving advanced practice roles, a three-stage developmental model with a task-oriented focus that is a poor fit for describing the emergence of the CNS role. According to Hanson and Hamric, in Stage I, nurses engage in on-the-job training to address unmet patient needs in a healthcare system by performing activities not valued by physicians yet not really a nursing role. In Stage II, organized, apprentice-type agency-specific training emerges with an emphasis on skill development. Anesthesia, midwifery, and nurse practitioner (NP) are offered as examples of specialties that began with apprentice-based training programs (Hanson & Hamric, 2003). In Stage III, graduate nursing education with a standardized curriculum emerges for the specialty. The model was modified by Salyer and Hamric (2008) with the addition of Stage IV, which encompasses the period when the specialty role is clearly articulated within the profession, is recognized by other providers, and has corresponding certification available for nurses in the specialty.

While this model may be descriptive of some advanced practice roles, it fails to describe the evolution of the CNS role and practice. The CNS role was conceived by nursing leaders to address a void in clinical practice expertise in nursing and, from the beginning, was intended to be an advanced nursing role, not a role to fill gaps for hospital tasks viewed as undesirable by physicians. CNS education did not begin as an institutional apprenticeship; it was initially designed to be graduate education. Apprentice-type training programs never existed for preparing the CNS for practice. Standardized educational expectations for CNSs

were not developed early on, resulting in an array of educational approaches. Initial CNS certification programs validated expertise, not entry level competence; eligibility requirements included at least 3 years of CNS practice experience. And while certification options were created for some specialties, not all nursing specialties offer advanced CNS certification opportunities.

Uncoupling “role” from “specialty” is critical to understanding the evolution of the CNS. The role, which is a set of functions, is different from specialty knowledge and skills and the context in which the role is practiced. Making a distinction between role and specialty facilitated the development of core role competencies applicable to all clinicians in the role while also facilitating implementation of the same role in different specialties. The NACNS (1998, 2004, 2008, 2019) core CNS practice competencies identify CNS role competencies regardless of specialty. Also, distinguishing role from specialty allows CNSs to expand practice into emerging and narrow specialties and thus fulfill the original intent of the role: to lead the advancement of nursing in meeting the public need for nursing care and services. An appropriate model describing the evolution for CNS role and practice, based on historical development of the role, is proposed as follows:

- Stage I: Scientific discovery, knowledge, and technology create a public need for nursing services in a new area. CNSs practicing in related specialties begin to interpret needs for nursing services in the new area.
- Stage II: CNSs combine new and existing scientific knowledge with existing clinical expertise and begin defining and providing nursing services in the area of need.
- Stage III: CNSs provide leadership for other nurses in providing services in the emerging specialty area by disseminating knowledge, role modeling, and mentoring to improve clinical outcomes. CNSs lead the development of norms and standards of care for nursing practice in the newly emerging specialty.
- Stage IV: CNSs engage in developing and promoting competency validation for nurses providing care to the specialty. Practice competencies are validated by professional certification or other mechanisms.

The importance of CNS practice in the overall advancement of the practice of all nurses is undervalued and overlooked. Early concerns about

improving the knowledge and skill of nurses resulted in the creation of the CNS as the clinical nurse experts to lead, mentor, teach, and advance the practice of nurses. Additional advanced nursing roles have since been created, some roughly following the model proposed by Hanson and Hamric (2003), others with different developmental trajectories. NPs are now the largest advanced practice group; however, in contrast to CNSs, NPs have been expanding nursing into areas of practice traditionally reserved for physicians, as have nurse anesthetists. In meeting the public’s need for services, other advanced practice roles are focused primarily on providing direct patient care that is similar to the care of other providers. The result is a loss of the unique contribution of nursing called for by E. L. Brown (1948) and Peplau (1965). Only the CNS role is educationally prepared in the three domains necessary for expanding the boundaries of nursing for all nurses and thus helping ensure a workforce for meeting the comprehensive public need for nursing services. Figure 1.1 depicts the differences in practice expansion focus of the CNS and NP.

With the roots of CNS practice nursing firmly grounded in clinical “nursing” practice, it was easy to confuse the professional role with an employer job description. In 1989, Hamric wrote that the CNS title was, unfortunately, being seen by some nurses as a professional attribute based on education and not a discrete work role. Boyle (1996) noted that the use of the CNS title by master’s-prepared nurses not functioning in the job role contributed to confusion about the role. Such statements represent confusion within the profession about the difference between professional role preparation and an employer-based job description. The lack of regulatory title protection by states and state boards of nursing perpetuated the misuse of the CNS title.

■ CNS EDUCATION

In 1943, the NLN appointed a committee to identify guiding assumptions and basic principles for developing clinically grounded postgraduate nursing courses (Mayo, 1944). The third guiding assumption stated,

The fundamental purpose of all advanced clinical nursing courses is the further preparation of qualified graduate nurses as clinical nursing specialists in order to ensure a constantly improving quality of nursing practice. (Mayo, 1944, p. 581)

FIGURE 1.1 Schema depicting CNS and NP practices expanding nursing practice in different directions.

CNS, clinical nurse specialist; NP, nurse practitioner.

Source: © Janet S. Fulton (2009) printed with permission.

This guiding assumption used the term *clinical nursing specialist* and linked the role to improved nursing practice. Written prior to the release of the 1948 Brown report, it is evidence of the nursing profession's self-awareness of the need to promote and advance quality clinical care, and a clinical nursing specialist was the vision for achieving this goal. It was also noted that advanced clinical courses would provide a path for professional advancement and dispel a prevailing myth that career advancement meant leaving nursing for another profession. Between 1944 and 1946, a Subcommittee of Nurse Specialists under the direction of the NLN Education Committee on Postgraduate Clinical Nursing Courses used the guiding assumptions and basic principles to develop four advanced specialty nursing practice curricula: maternity, pediatrics, psychiatry, and tuberculosis.

Graduate nursing education slowly became available, yet very few nurses held bachelor's degrees and it was difficult to establish cohorts of baccalaureate-prepared nurses for master's-level classes. Throughout the 1940s and 1950s, diploma- and bachelor-prepared nurses often enrolled in the same courses; the only determinant of the degree granted was the degree held upon enrollment. Course content varied widely and did not always contain theory and science. During this same time, specialty education was largely controlled by hospitals and used by administrators to recruit nurses and manipulate the nursing workforce for hospital goals (Smoyak, 1976). Not until theory, science, and specialty practice knowledge were embedded in academic curricula did the reality of a graduate-prepared specialist as expert

clinician emerge. The first graduate specialty program to prepare only CNSs as expert clinicians was the graduate program in advanced psychiatric nursing at Rutgers University. The design and delivery of the program as a specialty-focused graduate program was important because up to that point graduate courses included students seeking options in administration or teaching and were not necessarily taught by faculty in the specialty or with an advanced degree (Smoyak, 1976).

Curriculum recommendations were developed for CNS educational programs but not formally organized as a curricular standard. The 1969 NLN report, *Extending the Boundaries of Nursing Education* (NLN, 1969), failed to reach a single definition of the CNS and called for the role to be flexible. However, a cluster of role components were identified: therapist/practitioner, teacher, consultant, researcher, and change agent. The therapist/practitioner component was a direct care provider in a specialty area of expertise and included assessment, diagnosis (called "interpreting cues"), and intervention. The teacher component included one-on-one bedside work with staff nurses, formal (classes) and informal (in-service) staff development programs, assessment of staff competencies, interpretation of the nursing literature, and developing staff nurses' skills. The consultant component was linked to the ability to move about in the system, from "unit to unit," providing expertise and knowledge as needed and responding to calls by staff nurses for assistance in problem-solving. Change agent was described as the ability to effect changes in the healthcare delivery system. No description of research was included in the report.

TABLE 1.3 NATIONAL LEAGUE FOR NURSING: EARLY CNS EDUCATIONAL REQUIREMENTS

<ul style="list-style-type: none"> • A broad base in the psychopathology and pathophysiology related to the clinical specialty. For example, even though the nurse planned to specialize in the nursing care of patients with neurological conditions, educational preparation should include a foundation in the whole medical–surgical nursing area.
<ul style="list-style-type: none"> • Knowledge and skills in the clinical practice of the specialty, and in teaching and research
<ul style="list-style-type: none"> • The behavioral sciences essential to the leadership role and to preparing graduates to be change agents
<ul style="list-style-type: none"> • Knowledge and understanding of the social framework in which healthcare is given. (Some conference participants believed that public health nursing concepts would be sufficient; others suggested a breadth of knowledge of social agencies and societal influences.)

CNS, clinical nurse specialist.

Source: From National League for Nursing. (1969). *Extending the boundaries of nursing education*. New York, NY: Author.

Emphasis was placed on the importance of having a CNS in the clinical setting able to move about without interference, being an integral part of the staff and thus being able to identify staff needs and help with professional development. To prepare a graduate student to perform competently in the role components, four educational requirements were recommended. These requirements are listed in Table 1.3.

The 1969 NLN report advocated four educational strands for all CNS educational programs: the process of nursing, the process of clinical nursing specialization, the process of scientific investigation, and the process of communication (Berlinger, 1969). In addition, each student was expected to evolve a philosophy of nursing practice congruent with a personal philosophy of nursing, and to adopt or develop a conceptual framework for nursing practice. Clinical experiences in the specialty area were recommended for the purpose of knowledge of scientific investigation, critical analysis of current research, the conduct of independent research, and the care of patients in the specific specialty.

Subsequent descriptions of CNS curricula were published with similarities but not agreement. McIntyre (1970) listed five essential content areas underpinning the CNS program at the University of California, San Francisco: (a) intense study and experience with complex, specialized health problems; (b) opportunity to use advanced technology; (c) deliberative and continuous exchange with members of other health professions; (d) participation with members of the community in the improvement of nursing care; and (e) opportunity to identify the unknowns in care, including participation in research. Rhein (1973) outlined the curriculum at the University of California Los Angeles, noting a strong emphasis on the care of patients and families with one academic quarter

of introduction to clinical practice and two quarters of actual clinical practice. The focus of clinical practice was assessment, diagnosis, and planning interventions for patients within a philosophical-conceptual framework. Rubin (1969) reported implementing a specialty-focused PhD degree for maternity and pediatric nursing at the University of Pittsburgh.

The number of CNS programs began to expand after the Nurse Training Act of 1964 (PL 88–581), Title II of the 1968 Health Manpower Act (PL 92–158), and the Nurse Training Act of 1975 (PL 94–63; Hawkins & Thibodeau, 1993). From 1974 to 1975, the NLN reported 65 universities offering master's programs in nursing with around 90% offering some type of clinical focus. Program titles varied, making it difficult to distinguish the specialty focus and depth of clinical experiences (Smoyak, 1976). By 1984, the NLN reported 129 accredited programs preparing CNSs (NLN, 1984). Walker et al. (2003) identified 157 separate CNS programs/majors offered by 139 different schools. In a national survey conducted several years later, Spross, Gerard, and France (2006) reported a total of 215 schools self-reporting CNS programs/majors. In 2018, the AACN reported a total of 101 CNS programs/majors in the United States (AACN, 2018).

From the inception of the role, the CNS title rarely was protected by statute or regulation. Nurses not prepared in CNS graduate programs assumed the title or were given the title “clinical specialist” by employers. In 1980, the ANA published the first edition of its *Social Policy Statement*, recognizing the CNS as an expert clinician with a specialty focus and a graduate degree. This document helped further entrench the expectation for CNS graduate education with a specialty focus.

The specialist in nursing practice is a nurse who, through study and supervised practice at the graduate level (master's or doctorate) has become an expert in a defined area of knowledge and practice in a selected clinical area of nursing. (ANA, 1980, p. 23)

Although CNS educational programs were becoming widely available, CNS curricula varied by school and specialty. Throughout the 1980s and most of the 1990s, many publications discussing CNS education appeared in the literature, but no organized effort came together to create national standards for CNS education. Schools continued to rely on the NLN recommendations to guide curricula. CNS graduate programs varied in length from 9 to 28 months, with most programs taking two full academic years to complete (Sills, 1983). Some programs were not designated CNS preparation programs, but were labeled the “clinical” option to distinguish them from administration and teaching-focused nursing programs. Other CNS programs were linked to a specialty with core graduate courses and separate curricular tracks for differing specialties. For example, between mid-1970 and mid-1990, the University of Cincinnati College of Nursing offered distinct CNS specialty tracks for pulmonary, medical–surgical, burn-trauma, occupational health, gerontology, oncology, adult mental health, and child/adolescent mental health.

In 1996, the AACN published *The Essentials of Master's Education for Advanced Practice Nursing* (AACN, 1996). The *Essentials* recommended content for advanced practice nursing curricula preparing clinical specialists, nurse midwives, nurse anesthetists, and NPs. In 1999, the National Advisory Council on Nurse Education and Practice (NACNEP), established by Title VIII of the Public Health Service Act to advise the secretary on nursing workforce issues, completed a comprehensive report addressing federal support for the preparation of the CNS workforce (NACNEP, 1999). Among the recommendations, the report called for the federal government to support and encourage the profession's efforts to standardize requirements for educational preparation for core competencies of the CNS role. In 1998, NACNS published the first edition of *The Statement on Clinical Nurse Specialist Practice and Education*, which included both core practice competencies for the CNS role and recommendations for educational preparation of the CNS. In 2003, Walker et al. found that 56% of schools preparing CNSs used the NACNS recommendations to guide curricula. The second edition

of the NACNS *Statement* was published in 2004 and again included core practice competencies and curricular recommendations for achieving the practice competencies. In 2019, NACNS published an updated *Statement* that included both curricular recommendations and criteria for the evaluation of CNS programs, including master's, practice doctorate, and post-master's certification programs. The program criteria reflect requirements necessary to ensure quality CNS education.

The APRN Consensus Model (National Council of State Boards of Nursing, 2008) included graduate-level educational recommendations for core content and clinical experience. Consistent with all APRN education programs, CNS programs were to include course work in physiology/pathophysiology, physical assessment, and pharmacology and a minimum of 500 supervised clinical practice hours in the CNS role.

■ MODELS OF CNS PRACTICE

The CNS role functional components identified in earlier works and summarized in the 1969 NLN report (therapist/practitioner, teacher, consultant, researcher, and change agent) became unifying descriptions of the CNS. Beginning in the 1980s, a number of models and frameworks were developed to further explain CNS practice, with the identified role functional components serving as central concepts. Some models described the structure of CNS, whereas others were process oriented, linking CNS practice to clinical outcomes. Few were developed using theory development and testing methods. Table 1.4 briefly summarizes models describing the CNS role and/or CNS practice.

The Emergence of the Subroles Model of CNS Practice

Throughout the 1980s, the “subroles” model was dominant, though it was more a descriptive listing of expected practice activities than a model demonstrating the relationships between and among the activities. Hamric (1983) was an early contributor to describing the CNS role as a constellation of “subroles,” including the direct care functions of expert practitioner, role model, patient advocate, and indirect care functions change agent, consultant/resource person, clinical teacher, supervisor, researcher, liaison, and innovator. In 1986, the ANA Council of Clinical Nurse Specialists published *The Role of the Clinical Nurse Specialist*, which listed

TABLE 1.4 BRIEF SUMMARY OF MODELS AND FRAMEWORKS FOR CNS PRACTICE

Reference	Summary
Roy and Martinez (1983)	A systems framework for CNS practice. Concepts include input, process, output, and feedback. A circular process where input influences processes, which in turn influence output, which generates feedback, which serves as continuing input. Outcomes described as “effects on nursing practice and nursing profession”
Girouard (1983)	The linkage model. Composed of two major systems—expert knowledge application system and internal problem-solving system. Each system has internal circular steps that lead to problem-solving. The systems interact through feedback loops. Outcome is “the nurse implements the planned change”
Hamric (1983)	Subroles of the CNS. Lists the direct care functions as expert practitioner, role model, and patient advocate. Indirect care functions are identified as change agent, consultant/resource person, clinical teacher, supervisor, researcher, liaison, and innovator. Relationships between/among subroles not defined or linked to outcomes
Calkin (1984)	Developed for nurse administrators to use in distinguishing novice, expert-by-experience, and advanced nurses’ performance. Used a series of normal distribution curves to illustrate levels of knowledge, skill, and patient population response (outcome). The model links practice to patient outcomes, but was never tested
Holt (1984)	Anatomy of a CNS. Provides a structural description of the role, including nature of the unit; goal of the unit; growth and development of the unit; deviations from expected developmental pattern; other units in the universe; and relationships and interventions
Fenton (1985)	An ethnographic study confirmed CNS practice in Benner’s seven domains of nursing practice—helping role; administering and monitoring therapeutic interventions and regimes; effective management of rapidly changing situations; diagnostic and monitoring function; teaching-coaching function; monitoring and ensuring quality of healthcare practices; and organizational and work–role competencies—and suggested an additional domain: Consulting role
S. J. Brown (1998)	Framework proposed to consolidate and integrate concepts from multiple sources to create a comprehensive model of advanced practice nursing. Consists of four domains—role legitimacy, advanced practice nursing, outcomes, and environment—and proposed relationships among the domains
NACNS (1998)	Describes core CNS competencies and relationships among competencies, skills, attributes, and outcomes in an environmental context that includes organizational structure, culture and processes, public policy, social factors, and human and fiscal resources

CNS, clinical nurse specialist.

the functions of the CNS role as specialist in clinical practice, educator, consultant, researcher, and administrator (ANA Council of Clinical Nurse Specialists, 1986). The administrator function was controversial, with arguments against including administration related to negating the clinical focus of the role. Arguments for including an administrative function were building an important option for situations where the CNS assumed responsibility for direct care programs in the area of specialization and maintains direct client-based practice (ANA Council of Clinical Nurse Specialists, 1986).

Multiple articles appeared through the 1980s and early 1990s using variations of Hamric’s (1983) subroles model to describe, explain, and measure CNS practice in many different specialties. In 1989, Hamric expanded her initial description

to include three foundational elements, called primary criteria, and to distinguish skills/competencies from subroles (Hamric, 1989). Primary criteria were those conditions required for beginning practice in the CNS role and included an earned graduate degree in nursing with a focus on clinical practice, certification by a professional nursing organization, and a practice focus on patient/client/family. Skills and competencies included in the revised model were change agent, collaborator, clinical leader, role model, and patient advocate. The functional competencies previously identified as subroles were changed to expert practice, consultation, education, and research. The rationale for categorizing an item as a competency or a functional subrole was not stated, appeared arbitrary, and did little to clarify the CNS role and practice within

nursing or to the public. Nonetheless, by the end of the 1980s, the subroles model of expert clinician, educator, and researcher was solidified as the structural description of the CNS role. Other subroles frequently associated with the CNS role were consultant, collaborator, role model, and change agent.

The subroles description became a *de facto* organizing framework for describing the structural components of the CNS role. Textbooks began emphasizing the subroles. Hamric and Spross's (1989) book included chapters describing each of the subroles, patient care provider, consultant, educator, researcher, collaborator, and clinical leader. Sparacino, Cooper, and Minarik's (1990) book included a chapter on each subrole—clinician, consultant, educator, researcher, administrator, and clinical leader. Gawlinski and Kern's (1994) text for critical care CNSs was organized according to subroles and included sections on practitioner, educator, consultant, researcher, and leader/manager. Multiple additional publications, articles, and books used the subroles framework.

At the same time, research about the CNS role was appearing in the literature using subroles as the organizing framework for the studies. This growing body of work helped codify the subroles model by designing data collection instruments for identifying activities associated with each subrole. It was typical for researchers to use questionnaires that asked CNSs to identify a percentage of time spent in each of the subroles and/or to identify activities in the subroles.

Critique of the Subroles Model

Despite its familiarity, or perhaps because of it, the subroles model has not been subject to sufficient critique as a model for describing CNS practice. A description of the CNS role as the additive sum of functional subroles is inadequate. A primary problem with the subroles model is that each of the subroles is a unique functional element within nursing, raising even more questions about the difference between a CNS, for example, executing the "educator subrole," and a nurse educator practicing in the educator role, especially where the nurse educator in a clinical setting is working directly with clients or staff. The subroles' model of a CNS became the equivalent of painting a "white dog in a snowstorm."

Three inadequacies of the subroles model are:

1. Conceptualizing the CNS role as the additive outcome of multiple discrete activities. In practice, the CNS role is highly integrated. CNS

practice brings an advanced, specialized perspective to identifying clinical questions and seeking alternative solutions. CNS practice is a way of thinking that incorporates complex, interdependent actions. This way of thinking is not easily captured in discrete units of time or activities.

2. Using subroles as proxy indicators for professional competencies. The lack of core practice competencies, coupled with no consensus on curricular standards for the CNS education, allowed the subroles, being broad and nonspecific, to serve as the only guide for education and contributed to inconsistency in role preparation and implementation. In addition, the lack of clear distinction between subrole, skills, and competencies in some models contributed to confusion between CNS role definition and CNS practice competencies.
3. Failing to level CNS practice relative to other levels of nursing practice. In the subrole model skill and competency descriptors for CNSs, including practitioner, educator, researcher, consultant, collaborator, change agent, patient advocate, and leader, are expected professional performance requirements for all professional nurses. What differentiates practice expectations among nursing roles is the level of practice and associated outcomes generally associated with the level of nursing education. For example, bachelor-prepared nurses engage in research activities, as do master's and doctorally prepared nurses, albeit not at the same level. Likewise, nurses at all levels of educational preparation are expected to teach patients and families, but the competency expectation and associated clinical outcome is different depending on a nurse's education and role. Unfortunately, the subroles model did little to distinguish CNS practice competencies and outcomes from other nursing roles.

The subroles model emerged as an outgrowth of many of the early writings about descriptions of an advanced clinical expert; however, it was never empirically tested for validity. It was, however, codified by a body of research work that accepted it *prima facie*, never really questioning or critiquing the underlying assumptions.

■ AN INTEGRATED MODEL OF CNS PRACTICE Core CNS Practice Competencies

After far too many years of waiting, core competencies for CNS practice were identified in the 1998

publication of the NACNS *Statement on Clinical Nurse Specialist Practice and Education*. The core practice competencies, created through a rigorous content analysis process, included an extensive review of the literature and interviews with practicing CNSs and administrators. A national external review panel was used to validate the final draft list of competencies (Baldwin et al., 2007). The resulting core competencies reflected CNS practice regardless of specialty. The core competencies were updated in 2004 (NACNS, 2004), and were subsequently validated through research (Baldwin, Clark, Fulton, & Mayo, 2009). The content analysis process used to define the core competencies also identified an organizing framework with three distinct domains. In 2019, NACNS released the most recent updated CNS core practice competencies (Appendix 1.1).

Domains of Practice

The final organizing framework for the core competencies describes CNS practice as integrated across three domains. The domains were patient/client, nurses and nursing practice, and organizations and systems (NACNS, 1998). The domains were labeled “spheres of influence” to denote the scope or breadth of practice activities and the target outcomes associated with a particular domain. The patient/client domain was considered central, reinforcing the long-standing view of CNS as clinical expert. The nurses/nursing practice domain

recognized that CNS practice included influencing the clinical practice of other nurses, working within the specialty to improve norms and standards of care that direct care delivered by others. The organizations/system domain reflected CNS practice in articulating the value of nursing at the organizational level and influencing decision-making at the system level to remove barriers and achieve improved patient outcomes (NACNS, 2004). CNSs are advanced practice nurses with a specialty focus; thus, the role core competencies were seen as actualized in specialty knowledge, standards, and skills, as demonstrated in Figure 1.2. Outcomes of CNS practice were also identified for each domain, demonstrating the link between CNS practice consistent with the core competencies and anticipated clinical outcomes.

This integrated model of CNS practice, commonly referred to as the spheres of influence model, is more descriptive of CNS practice than the previous additive subroles model. The creation of core competencies brought greater clarity to curriculum content by giving educators practice performance expectations for graduates. Identifying core competencies and expected outcomes also informed employers, the public, and other providers what to expect from CNS practice.

In 2019, NACNS updated the model to be more inclusive of external concepts influencing CNS practice. External concepts added to the model include healthcare environment, societal needs [for nursing care], interprofessional collaboration,

FIGURE 1.2 Spheres of influence model. Clinical nurse specialist practice conceptualized as core competencies in three interacting spheres actualized in specialty practice and guided by specialty knowledge and specialty standards.

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FIGURE 1.3 Spheres of impact model. CNS practice conceptualized as the core competencies in three interacting spheres actualized in specialty practice, and guided by specialty knowledge, skills/competencies, and standards of practice within the context of the ever-changing healthcare environment, healthcare policy, interprofessional collaboration, and societal needs. The core is the foundation upon which to build specialty competencies.

CNS, clinical nurse specialist.

Source: © National Association of Clinical Nurse Specialists. (2019). *Statement on clinical nurse specialist practice and education* (3rd ed.). Reston, VA: Author; reprinted with permission.

and healthcare policy. The domains of practice, or spheres, were changed to spheres of impact to reflect an outcomes orientation (Figure 1.3).

■ OPPORTUNITIES FOR THE FUTURE

The CNS is an expanded nursing role prepared at the graduate level, either master's or doctorate. CNSs acquire and apply scientific knowledge and skills for the purpose of meeting the public need for clinically expert nursing services with both newly emerging and established specialty populations. CNSs are leaders in providing innovative nurse-initiated interventions, resulting in improved health outcomes for specialty populations. Federal legislation is shifting healthcare priorities and opening up new opportunities to meet long-standing and emerging needs for nursing care. Technology and informatics are shaping the future. CNSs should embrace challenges, create opportunities to shape new legislative initiatives, and incorporate technologies into practice.

Affordable care organizations, telehealth, health/medical homes, genetically optimal pharmaceuticals, expanded options for end-of-life care, and other emerging healthcare innovations provide endless opportunity for CNSs to lead nursing into the future.

Across literally hundreds of articles written about the CNS role and practice, the descriptions and expectations show remarkable consistency. Unfortunately many publications include a commentary noting CNS role ambiguity, alluding to, and a poor understanding of, CNS practice by nurses, administrators, and other healthcare providers. Continued assertion about CNS role ambiguity is a curiosity, given the many CNSs successfully practicing in the role and the many administrators supporting the role. Since inception, the CNS role and associated practice competencies have focused on interpreting and advancing nursing practice for the betterment of the health of the public. Ambiguity about the CNS role likely is further reflection of a lack of clarity about nursing, nursing practice, and the unique contributions nursing makes to

the public good. Understanding the CNS role and practice is inextricably tied to the ability to articulate the value of nursing. As a profession, nursing often lacks the ability to express its contributions to health; thus, it becomes even more challenging to describe an ambiguous nursing profession that is practiced at an advanced level.

Thus is the dual challenge for CNSs in the future—to continue moving forward with the advice offered by E. L. Brown (1948): to clearly articulate the unique contributions of nursing to patient care while describing, implementing, and evaluating nursing practice at an advanced level. The message is further difficult to manage when nursing care and CNS practice outcomes are not documented, measured, and reported. The next decade should be dedicated to intense efforts at documenting and measuring CNS practice outcomes. To do this, models and frameworks that link CNS practice to clinical outcomes need to be developed—models with theoretical and empirical support. As CNSs successfully address practice model development and outcomes measurement, much will be achieved for the benefit of our patients, their families, and general public welfare.

DISCUSSION QUESTIONS

- Discuss the significance of collegiate education on the emergence of the CNS role. What social, professional, and regulatory influences surrounded moving nursing education from the hospital training program to university academic programs? How have these influences changed over time, and are they similar or nonexistent today?
- Develop a framework for the CNS practice. Identify themes and concepts in early descriptions of the CNS role. How are those same concepts found in today's CNS practice? How might the concepts be organized into a practice framework?

ANALYSIS AND SYNTHESIS EXERCISES

- Clinical expertise in nursing practice is central to the CNS role and practice. Trace the development of a selected specialty practice. Explore the relationships among the specialty and scientific knowledge development, technological influences, and public need for nursing services.
- Analyze trends in nursing that influenced development of nursing and the CNS role. The *American Journal of Nursing* is electronically archived in JSTOR and available through Google Scholar;

explore this historical literature for influences on today's CNS role.

CLINICAL APPLICATION

Identify methods for measuring outcomes related to CNS practice competencies. Compare and contrast variations in methods and data needed to measure the same outcome in different specialties.

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APPENDIX 1.1

CLINICAL NURSE SPECIALIST CORE PRACTICE COMPETENCIES

Patient Direct Care Sphere

Patient: Represents patient, family, healthcare surrogate, community and population.

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

- P.1. Uses relationship-building communication to promote health and wellness, healing, self-care, and peaceful end-of-life.
- P.2. Conducts a comprehensive health assessment in diverse care settings including psychosocial, functional, physical, and environmental factors.
- P.3. Synthesizes assessment findings using advanced knowledge, expertise, critical thinking, and clinical judgment to formulate differential diagnoses.
- P.4. Designs evidence-based, cost-effective interventions, including advanced nursing therapies to meet the multifaceted needs of complex patients.
- P.5. Implements customized evidence-based advanced nursing interventions, including the provision of direct care.
- P.6. Prescribes medications, therapeutics, diagnostic studies, equipment, and procedures to manage the health issues of patients.
- P.7. Designs and employs educational strategies that consider readiness to learn, individual preferences, and other social determinants of health.
- P.8. Uses advanced communication skills in complex situations and difficult conversations.
- P.9. Provides expert consultation based on a broad range of theories and evidence for patients with complex healthcare needs.
- P.10. Provides education and coaching to patients with complex learning needs and atypical responses.
- P.11. Evaluates impact of nursing interventions on patients' aggregate outcomes using a scientific approach.

P.12. Leads and facilitates coordinated care and transitions in collaboration with the patient and interprofessional team.

P.13. Facilitates patient and family understanding of the risks, benefits, and outcomes of proposed healthcare regimens to promote informed, shared decision-making.

P.14. Facilitates resolution of ethical conflicts in complex patient care situations.

P.15. Analyzes the ethical impact of scientific advances, cost, clinical effectiveness on patient and family values, and preferences.

P.16. Advocates for patients' preferences and rights.

Nurses and Nursing Practice Sphere

Nurses and Nursing Practice: The CNS advances nursing practice to achieve optimal outcomes by ensuring that nurses and nursing personnel utilize evidence-based practices to meet the multifaceted needs of patients and/or populations.

N.1. Provides expert specialty consultation to nurses related to complex patient care needs.

N.2. Promotes interventions that prevent the impact of implicit bias on relationship building and outcomes.

N.3. Advocates for nurses to practice to the full extent of their role in the delivery of healthcare.

N.4. Leads efforts to resolve ethical conflict and moral distress experienced by nurses and nursing staff.

N.5. Fosters a healthy work environment by exhibiting positive regard, conveying mutual respect, and acknowledging the contributions of others.

N.6. Employs conflict management and negotiation skills to promote a healthy work environment.

N.7. Assesses the nursing practice environment and processes for improvement opportunities.

N.8. Uses evidence-based knowledge as a foundation for nursing practice to achieve optimal nurse-sensitive outcomes.

(continued)

- N.9. Mentors nurses and nursing staff in using evidence-based practice principles.
- N.10. Leads nurses in the process of planning, implementing, and evaluating change considering intended and unintended consequences.
- N.11. Evaluates the outcomes of nursing practice using methods that provide valid data.
- N.12. Facilitates opportunities for nurses, students, and other staff to acquire knowledge and skills that foster professional development.
- N.13. Engages nurses in reflective practice activities that promote self-awareness and invite peer feedback to improve the practice of nursing.
- N.14. Mentors nurses to analyze legislative, regulatory, and fiscal policies that affect nursing practice and patient outcomes.

Organization/System Sphere

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

- O.1. Cultivates a practice environment in which mutual respect, communication, and collaboration contribute to safe, quality outcomes.
- O.2. Uses leadership, team building, negotiation, collaboration, and conflict resolution skills to build partnerships within and across systems and/or communities.
- O.3. Consults with healthcare team members to integrate the needs, preferences, and strengths of a population into the healthcare plan, to optimize health outcomes and patient experience within a healthcare system.

- O.4. Leads and participates in systematic quality improvement and safety initiatives based on precise problem/etiology identification, gap analysis, and process evaluation.
- O.5. Provides leadership for the interprofessional team in identifying, developing, implementing, and evaluating evidence-based practices and research opportunities.
- O.6. Partners with research-focused, doctorally prepared (e.g., PhD) colleagues to translate, conduct, and disseminate research that addresses gaps and improves clinical knowledge and practice.
- O.7. Leads and participates in the process of selecting, integrating, managing, and evaluating technology and products to promote safety, quality, efficiency, and optimal health outcomes.
- O.8. Leads and facilitates change in response to organizational and community needs in a dynamic healthcare environment.
- O.9. Evaluates system-level interventions, programs, and outcomes based on the analysis of information from relevant sources.
- O.10. Demonstrates stewardship of human and fiscal resources in decision-making.
- O.11. Disseminates CNS practice and fiscal outcomes to internal stakeholders and to the public.
- O.12. Promotes nursing's unique contributions to advancing health to stakeholders (such as the organization, the community, the public, and policy makers).
- O.13. Advocates for equitable healthcare by participating in professional organizations and public policy activities.
- O.14. Advocates for ethical principles in protecting the dignity, uniqueness, and safety of all.

Source: National Association of Clinical Nurse Specialists. (2019). *Statement on clinical nurse specialist practice and education* (3rd ed.). Reston, VA: Author. Reprinted with permission.