



Third Edition

STATEMENT ON
**Clinical Nurse
Specialist Practice**
and **Education**

ACKNOWLEDGMENTS

The National Association of Clinical Nurse Specialists (NACNS) Board of Directors is indebted to the work of our members, including those engaged in past editions of the *Clinical Nurse Specialist Statement on Practice and Education* and the development and revision of the CNS core competencies. This edition truly is grounded in the prior work contributed by these experts. The Task Force for the Revision of the *Statement on Clinical Nurse Specialist Practice and Education* is comprised by conscientious, thorough, and hardworking CNS leaders that represent different types of CNS practice, research, and education. The combined wisdom and talent of these invaluable members has resulted in this revised document.

Members of the 2019 NACNS Statement on Clinical Nurse Specialist Practice and Education Task Force:

Carol Manchester, MSN, APRN, ACNS-BC, BC-ADM, CDE; Chair
Sherri L. Atherton, MS, RN, CNS-BC, CIC
Kathy A. Baker, PhD, APRN, ACNS-BC, FAAN
Niloufar Niakosari Hadidi, PhD, APRN, CNS-BC, FAHA
Mary Beth Modic, DNP, APRN-CNS, CDE, FAAN
Mary Fran Tracy, PhD, APRN, CCNS, FCNS, FAAN
Jane Walker, PhD, RN, CNS
Terri Nally, Consultant

Furthermore, NACNS would also like to recognize the review workgroup for the Revision of the *Statement on CNS Practice and Education*.

Tracy Chamblee, PhD, APRN, PCNS-BC, CPHQ, CPPS
Carrie Doyle, DNP, APRN, ACNS-BC
Niloufar Niakosari Hadidi, PhD, APRN, CNS-BC, FAHA
Anne Hysong, MSN, APRN, CCNS, ACNS-BC, FCNS
Carol Manchester, MSN, APRN, ACNS-BC, BC-ADM, CDE
Ginger Pierson, PhD, RN, CCRN, CCNS, FCNS
Mary Fran Tracy, PhD, RN, APRN, CCNS, FCNS, FAAN

The NACNS also wishes to recognize the authors of the second edition of the *NACNS Statement on Clinical Nurse Specialist Practice and Education (2004)*.

Angela P. Clark, PhD, RN, CNS, FAAN, FAHA; Co-Chair
Sue Davidson, PhD, RN, CNS; Co-Chair
Kathleen Baldwin, PhD, RN, ACNS-BC, ANP-BC, GNP-BC
Janet Bingle, MS, RN, CNS
Karen Clark, MSN, RN, CCRN
Nancy Dayhoff, EdD, RN, CNS
Janet S. Fulton, PhD, RN, ACNS-BC, FAAN
Peggy Gerard, DNS, RN, CNS
Barbara J. Hasbargen, MSN, RN, CNS, CNN
Brenda L. Lyon, DNS, RN, CNS, FAAN
Theresa Murray, MSN, RN, CCRN, CNS
Jo Ellen Rust, MSN, RN, CNS
Beverly B. Tidwell, DNS, RN, CNS

TABLE OF CONTENTS

Preface

- 04 History of the *Statement on Clinical Nurse Specialist Practice and Education*
- 04 The 2010 CNS Core Competency Revision
- 05 The Third Edition and Its Focus
- 05 The Development Process for the Third Edition

Chapter 1

- 07 Introduction
- 08 Parameters of the *Statement*
- 08 Goals of the *Statement*

Chapter 2

- 09 **Clinical Nurse Specialist Practice**
- 09 Definition of the Clinical Nurse Specialist
- 11 Social and Professional Mandate for Clinical Nurse Specialist Practice
- 13 Clinical Nurse Specialists in Relation to Other APRN Roles
- 14 APRN Consensus Model and the Clinical Nurse Specialist
- 15 Specialty Practice and Licensure for the Clinical Nurse Specialist
- 16 Clinical Nurse Specialists in Relation to Other Nurses with Master's and Doctoral Degrees
- 17 Relationships between Clinical Nurse Specialist Practice, Specialty Knowledge, and Practice Standards
- 18 Conceptual Model of Clinical Nurse Specialist Practice
- 18 Clinical Nurse Specialist Practice: Patient Direct Care Sphere
- 20 Clinical Nurse Specialist Practice: Nurses and Nursing Practice Sphere
- 21 Clinical Nurse Specialist Practice: Organizations/Systems Sphere
- 23 Legislative and Regulatory Issues Related to Clinical Nurse Specialist Practice
- 24 Professional Validation of Clinical Nurse Specialist Competencies

Chapter 3

- 25 **Clinical Nurse Specialist Core Competencies**
- 25 Introduction
- 25 Domains of the Core Competencies
- 25 Conceptual Framework: Core Competencies by Spheres of Impact

Chapter 4

- 29 **Outcomes of Clinical Nurse Specialists**
- 29 Introduction
- 29 Conceptual Framework: Outcomes of Clinical Nurse Specialists by Spheres of Impact

Chapter 5

- 32 **Recommendations for Graduate Preparation of Clinical Nurse Specialists**
- 32 Introduction
- 32 History and Evolution of Clinical Nurse Specialist Education
- 34 Curricular Recommendations
- 51 Essential Core Content Areas for Developing Clinical Nurse Specialist Competencies
- 56 Additional Educational Preparation Summary

Chapter 6

- 58 **Criteria for the Evaluation of Clinical Nurse Specialist Master's, Practice Doctorate, and Postgraduate Certificate Educational Programs**
- 58 Introduction
- 58 Criteria for the Evaluation of Clinical Nurse Specialist Master's, Practice Doctorate, and Postgraduate Certificate Programs
- 58 Criterion 1. Clinical Nurse Specialist Program Organization and Administration
- 60 Criterion 2. Clinical Nurse Specialist Program Resources: Faculty, Clinical, and Institutional
- 65 Criterion 3. Student Admission, Progression, and Graduation Requirements
- 67 Criterion 4. Clinical Nurse Specialist Curriculum
- 68 Criterion 5. Clinical Nurse Specialist Program Evaluation

References

73

Appendices

- 75 Appendix A: Glossary of Key Terms
- 77 Appendix B: Consensus Model for APRN Legislation, Accreditation, Certification, and Education
- 81 Appendix C: Content Validation Participants

Figures and Tables

- 17 Figure 1. Clinical Nurse Specialist Practice Conceptualized as the Core Competencies in Three Interacting Spheres
- 26 Table 1. Core Clinical Nurse Specialist Competencies
- 29 Table 2. Outcomes of Clinical Nurse Specialists
- 36 Table 3. Alignment of Competencies, Outcomes and Curricular Recommendations

PREFACE

In 1995, the National Association of Clinical Nurse Specialists (NACNS) was formed to be the national organization specifically dedicated to clinical nurse specialist (CNS) issues and to promote the unique practice of CNSs. Almost 25 years later, the association continues to support the CNS role.

NACNS Mission

To advance the unique expertise and value the clinical nurse specialist contributes to healthcare.

NACNS Goals

The NACNS will:

- Promote the full scope of practice of the CNS;
- Serve as the national leader for CNS education;
- Promote the benefit the CNS brings to evidenced-based quality care, patient safety, and cost savings in healthcare delivery; and
- Promote research that evaluates the efficacy and value of CNS interventions and practice.

History of the *Statement on Clinical Nurse Specialist Practice and Education*

The NACNS has engaged in strategies to articulate CNS practice competencies, educational guidelines, and credentialing requirements since 1998. Following the founding of NACNS, the organization's Board of Directors and members identified an urgent need for a national statement that would define CNS competencies and contributions to the healthcare of society. The NACNS's entry into the national dialogue offered the content needed to assist in differentiating the practice and education of the CNS role from the other three advanced practice roles.

The First Edition of the *Statement on Clinical Nurse Specialist Practice and Education* (1998) represented an effort to articulate the competencies and educational outcomes of the CNS role. This edition contained a comprehensive review of the CNS role including a historical perspective, a conceptual model of CNS practice, CNS competencies and outcomes, and CNS educational recommendations as well as a comprehensive reference list. This original statement was widely vetted by CNS students, practicing CNSs, CNS employers, schools of nursing, nursing associations, boards of nursing, and other interested parties. This document is the NACNS's foundational work on the CNS role.

The Second Edition of the *Statement on Clinical Nurse Specialist Practice and Education* (2004) updated the original and was designed to meet four goals:

- Articulate competencies for CNS practice and associated outcomes;
- Make explicit the contributions of CNSs in meeting societal healthcare needs;
- Provide a foundation for core CNS credentialing including certification examination, portfolio or other mechanisms; and
- Provide a standardized framework for CNS education at the graduate level.

The 2010 CNS Core Competency Revision

In 2006, as the nursing profession moved toward a consensus-based model for a cohesive and collaborative approach to licensure, accreditation, certification, and education of Advanced Practice Registered Nurses (APRNs) (i.e., CNS, certified nurse practitioner [CNP], certified nurse midwife [CNM], and certified registered nurse anesthetist [CRNA]), NACNS and the APRN Consensus Workgroup requested that the American Board of Nursing Specialties (ABNS) and

the American Nurses Association (ANA) convene and facilitate the work of a National CNS Competency Task Force, using the *National Consensus-Building Process to Develop Nationally Recognized Education Standards and Role/Specialty Competencies* identified by the APRN Consensus Workgroup in its early work together.

Representatives from CNS stakeholder groups were convened in May 2006 to participate in a national project to identify, validate, and achieve consensus on core CNS competencies relevant to the entry-level CNS, regardless of specialty, population, or setting. Twenty-seven individuals representing 22 organizations participated on the Task Force to identify and validate core CNS competencies. These individuals represented those most familiar with CNS practice and certification, and included practicing CNSs, educators, managers, staff of organizations offering CNS certification, and members of the NACNS.

The final product of this work was the *Clinical Nurse Specialist Core Competencies* (2010). This document, after wide discussion and debate, was intended to serve as a replacement for the CNS core competencies published in the earlier editions of the *Statement on Clinical Nurse Specialist Practice and Education*. This work was endorsed by 20 national nursing organizations.

The Third Edition and Its Focus

The following content represents the third edition of the *Statement on Clinical Nurse Specialist Practice and Education* (2019). The intent of this revision is to again combine into a single document, all components of the original *Statement on Clinical Nurse Specialist Practice and Education*.

This document is the result of diligent expert authorship, review, and input from NACNS members, professional associations, and other entities that represent, educate, and/or employ the CNS. The Task Force for the Revision of the *Statement on Clinical Nurse Specialist Practice and Education* was appointed at the end of 2015. The Task Force members determined that with 20 years of experience since the 1998 original statement in relation to education and employment of CNSs, it was important to revisit the original *Clinical Nurse Specialist Statement* and the 2004 *Statement* revision to update key sections. Readers will note:

- An updated conceptual model of the CNS;
- A change in terminology from spheres of influence, to spheres of impact;
- A refined approach to the presentation of the CNS competencies that consolidates and refines the competencies under the three spheres of impact;
- An enhanced discussion of the social mandate of the CNS;
- A discussion of the *Consensus Model for APRN Licensure, Accreditation, Certification, and Education*, and
- An expanded reference list.

The Development Process for the Third Edition

While appointed at the end of 2015, the Task Force work encompassed a significant part of 2016 and 2017. During this time, the group analyzed the key components of the document, determined their approach to revision, conducted and analyzed the available literature on the CNS role, and wrote their revision.

Feedback was solicited from NACNS members throughout the stages of the revision by holding open forums at the 2016, 2017, and 2018 annual NACNS meetings where feedback was solicited and incorporated into the document. The Task Force sought input from the Board of Directors on the initial concepts and then proceeded with the first of two public comment periods. Because of the reconceptualization and presentation of the CNS core competencies, this section of the document was published for member and public comment on November 2017-January 2018. Over 200 comments were received and these responses were individually analyzed to further refine the CNS core competencies.

The revisions to other sections of the *CNS Statement* soon followed, which allowed for the publication of the entire document for public comment in May 2018. This comment period was open first to members and then the public in order to provide for comprehensive feedback. These comments were integrated into the next review of the document.

On July 19, 2018, NACNS held a content validation panel meeting to provide structured partner input to the draft *Third Edition Statement on Clinical Nurse Specialist Practice and Education*¹. The content validation panel process integrated the public comments from the May 2018 comment period and perspectives from CNS experts across the nation identified by the Task Force, as well as input from representatives of over 20 organizations that were invited to participate in the content validation process at the July 19, 2018 meeting. A list of organizations and CNS expert and association participants is included in Appendix C.

The content validation process utilized a content validation tool (Lynn, 1986). The Task Force felt it was imperative to have CNS experts and nursing association representatives provide a comparative review in addition to their expert opinion. Therefore, each participant was asked to rate the different sections of the draft *Third Edition Statement on Clinical Nurse Specialist Practice and Education* according to Lynn's content validation tool.

An important finding was that using the content validation tool, all sections of the draft *Third Edition Statement on Clinical Nurse Specialist Practice and Education* received scores on the Lynn tool that indicated the reviewers rated this document as having content validation. The survey requested of the CNS experts and content validation team prior to the July 19th meeting included five separate documents that comprised the draft *Third Edition Statement on Clinical Nurse Specialist Practice and Education*. Using the Lynn scale, this survey found that all areas of focus included in the content validation survey scored a mean greater than 3.00, indicating their content validity using Lynn's scale. None scored a mean of 4.00, the highest possible score, suggesting they could all benefit from some level of discussion and modification by the content validation panel. Areas of the document that had lower validation scores were prioritized for deeper discussion. Over the course of the meeting, participants identified the specific issues and content gaps that existed in the document. The Content Validation Panel report was presented to the NACNS Board of Directors and a final review team comprised of representatives from the Board of Directors and Task Force was appointed to review the recommendations and finalize the document.

The NACNS is proud to publish the **Third Edition** of the *Statement on Clinical Nurse Specialist Practice and Education*. This document reflects the expertise of a wide representation of nursing and CNS leaders in the United States (U.S.). This document is intended to be a foundation for all CNSs regardless of practice environment, educational preparation, and specialty.

¹ Purcell F. Workbook for NACNS core documents content validation process. Cardinal Waypoint LLC, July 18, 2018. The workbook includes the results of the second survey, text excerpts of the six focus areas, content validation related comments derived from both the public and the content validation team surveys, and editorial comments to the five documents as a whole.

CHAPTER 1

INTRODUCTION

Clinical nurse specialists (CNSs) are a group of over 70,000 advanced practice registered nurses (APRN) (NACNS, 2017). In 1995, the National Association of Clinical Nurse Specialists (NACNS) was formed as the national organization dedicated to CNS issues and promoting the unique practice of CNSs. NACNS has since been a leader in articulating CNS practice competencies, educational guidelines, and credentialing requirements. As the only association that represents solely the CNS, we are uniquely positioned to revise and publish this key role-defining document. This document again combines the CNS core competencies and expected outcomes that define CNS practice with recommendations for graduate preparation for the CNS in this *Third Edition Statement on Clinical Nurse Specialist Practice and Education*.

Much has changed since this document was first published in 2004 and the core competencies were revised in 2010. Implementation of healthcare reform is continuously occurring as evidenced by the passage of the Patient Protection and Affordable Care Act and the 2008 release of the *Consensus Model of APRN Licensure, Accreditation, Certification, and Education (APRN Consensus Model)* (APRN Joint Dialogue Group, 2008). This revised *Statement* reflects those changes. The NACNS recognizes that nursing and APRN practice environments are constantly changing; therefore, by definition, this *Statement* is an evolving document and will continue to be shaped over time. However, the *Statement* will always reflect NACNS's commitment to ensuring that society benefits from the full range of nursing services and competencies characteristic of CNS practice. This document attempts to capture the full scope of practice for the CNS, though this scope of practice will be guided by local, state, and national laws and regulations.

As the preface outlines, NACNS incorporated national consensus on CNS competencies and outcomes in this statement. Content validation was used to best articulate the contributions the CNS brings to the forefront of healthcare in helping to shape the national agenda for education, public policy, professional practice, and performance standards.

Chapter 2 of this *Statement* defines the CNS and describes CNS practice in an effort to capture the significant changes in our profession in light of today's evolving healthcare environment. Chapter 2 provides a conceptual model of CNS practice and describes the social mandate for CNS practice; the relationship between CNS practice, specialty knowledge, and practice standards; and the regulation and validation of CNS practice. Chapters 3 and 4 focus on the competencies and outcomes of CNS practice across the three spheres of impact. Chapter 5 explains the recommendations for graduate preparation of CNSs to achieve the core competencies described in Chapter 3. Chapter 6 provides criteria for evaluating CNS programs. Appendix A is a glossary of key terms used throughout the document. Appendix B contains the 2008 *Consensus Model for APRN Legislation, Accreditation, Certification and Education (APRN Consensus Model, 2008)*.

Parameters of the *Statement*

Clinical expertise in a specialty is the hallmark of CNS practice. For the CNS, entry into practice occurs at the level of the master's or doctoral nursing degree. This *Statement* describes core baseline competencies for CNS entry into practice regardless of population foci, specialty, or education level of CNS preparation. Mastery of the competencies is achieved with experience and continuing education.

In 2004, a conceptual model was outlined that described the CNS competencies using three spheres of influence as the framework (NACNS, 2004). Clinical nurse specialist practice was defined to include the patient sphere, the nurses/nursing practice sphere, and the organizations/systems sphere. This *Statement* contains an important revision: the original model is updated and the three spheres are renamed the “three spheres of impact.”

The NACNS recognizes that, depending on population foci, specialty, settings, and other factors, actualization of individual CNS practice may vary. This document describes the competencies for the entire framework for the full scope of practice of the CNS. A philosophical underpinning of this work is the concept that the primary focus of the CNS role is to improve care to optimize the health of the patient/family in the context of their communities.

The competencies required for specific CNS specialty practice are not addressed in this document. Individual CNSs are expected to define their practice using this *Statement* with other relevant competencies related to their population foci and specialty standards from specific specialty organizations. By defining core competencies, this *Statement* has implications for legislation, accreditation, certification, and education as well as laws, regulation, and credentialing. It articulates the unique competencies of CNS practice and the education necessary to support that practice. This *Statement* does not and is not intended to compare CNS practice with the practice of other advanced practice nursing roles.

Goals of the *Statement*

The purpose of the *Statement* is to describe entry-level competencies and associated outcomes for CNS practice regardless of population foci and/or specialty across the three spheres of impact. Population foci and/or specialty competencies should overlay the entry-level competencies to provide more specification or emphasis among the competencies across the three spheres.

The three *Statement* goals are to:

- Make explicit the contributions of the CNS in meeting societal healthcare needs.
- Articulate core competencies for CNS practice and associated outcomes.
- Provide a standard framework for CNS education at the graduate level.

CHAPTER 2

Clinical Nurse Specialist Practice

Definition of the Clinical Nurse Specialist

The CNS is one of the four APRN categories recognized by the authors of the APRN Consensus Model, the National Council of State Boards of Nursing (NCSBN), individual state boards of nursing, the American Nurses Association (ANA), and the International Council of Nurses (ICN). Clinical nurse specialists are licensed registered nurses (RN) who have graduate preparation (master's or doctorate) in nursing as a CNS. They have unique and advanced level competencies that meet the increased needs of improving quality and reducing costs in our healthcare system. They provide direct patient care including assessment, diagnosis, and management of patient healthcare issues. Clinical nurse specialists are recognized for Part B participation in Medicare, Title 18 and may independently bill for those services. They also are recognized as eligible for Medicare's Primary Care Incentive Program in the Patient Protection and Affordable Care Act. Clinical nurse specialists have prescriptive privileges in 39 states (NACNS, 2016).

Clinical nurse specialists are one of four categories of APRNs, each role with distinctively different practice characteristics. While all four groups—CNSs, CNPs, CNMs, and CRNAs—have their origins in professional and statutory definitions of nursing, each group's practice has expanded and evolved in diverse ways beyond required APRN core competencies to meet different aspects of the health needs of individuals, families, populations, and communities. Each category of advanced practice nursing has a knowledge base unique to its practice to support its distinctive contributions.

The essence of CNS practice is advanced clinical expertise in diagnosis and intervention to prevent, remediate, or alleviate illness and promote health with a defined specialty population—be that specialty broad or narrow, well established or emerging. The totality of CNS expert clinical practice is manifest in the advanced care of patients (for example, individuals and families) and impacts populations and communities. This advanced practice role includes the autonomous authority to assess, diagnose, and initiate orders for treatment and therapy to include prescriptive authority for pharmacologic and non-pharmacologic therapies (APRN Consensus Work Group, 2008).

The CNS role builds on the nursing scope of practice to also include expansion of the nursing role in the development of those advanced skills. This practice is based on the CNS's direct care expertise and advanced knowledge and skills as expressed in the CNS core competencies in this *Statement*. The work of the CNS includes, but is not limited to, diagnosis and treatment of acute or chronic illness in an identified population with emphasis on specialist care for at-risk patients and/or populations. That work is achieved independently or in collaboration with the interprofessional healthcare team.

Clinical nurse specialists, in the implementation of their role, are leaders and facilitators of change, coordinators of specialized care, and implementers of evidence-based care within/between organizations to facilitate quality improvement, patient safety, and lower healthcare costs. While CNSs vary in their direct care role, their scope of practice includes the ability to prescribe medications, durable medical equipment, and medical supplies. They may also order, perform, and/or interpret diagnostic tests including lab

work and X-rays. Clinical nurse specialist practice extends from wellness to illness and from acute to primary care. As such, the CNS may provide health promotion, health teaching, and disease prevention to a range of patients, from primary care to the acute and/or chronically ill. The CNS is engaged in improving and role-modeling expert nursing practice and teaches RNs and other healthcare professionals working in clinical settings (NACNS, 2016).

The knowledge the CNS gains in direct practice with patients and families is frequently translated into improvements in entire patient populations, though the focus of CNS care is at the patient/family level. CNS practice is the translation of advanced clinical expertise, expert knowledge, complex decision-making skills, and clinical competencies necessary for expanded practice to directly provide and influence care and outcomes of individuals, categories of patients, and/or communities.

Clinical nurse specialist practice also transforms systems (such as healthcare institutions and systems, political systems, and public and professional organizations) to mobilize and change through expertly designed and implemented nursing interventions. Clinical nurse specialists are uniquely qualified to improve healthcare in the achievement of all six aims of the Institute of Medicine (IOM) report: having healthcare that is safe, effective, patient-centered, timely, efficient, and equitable (IOM, 2001). Thus, CNS practice is consistently directed toward achieving quality, cost-effective, patient-focused outcomes across all three spheres of impact. Illness may occur whether or not a patient has a disease (see Appendix A for the glossary with definitions of illness and patient). Clinical nurse specialists who care for patients experiencing illness with disease etiologies are also experts in assisting with disease-related diagnoses and interventions.

In addition to the direct care role of all APRNs, CNSs are leaders of change in healthcare organizations, developers of scientific evidence-based programs to prevent avoidable complications, and coaches of those with chronic diseases to prevent hospital readmissions. Clinical nurse specialists are facilitators of interprofessional teams in acute and chronic care facilities to improve the quality and safety of care including preventing hospital-acquired infections, reducing lengths of stay, and preventing hospital readmissions. The CNS uses system-level knowledge to lead improvements in patient care and outcomes.

Clinical nurse specialists practice in all states and there are licensed independent CNS practitioners in 24 states (NACNS, 2015b). As licensed independent practitioners, CNSs are expected to practice under standards established or recognized by a licensing body (i.e., a state board of nursing). As recognized APRNs, CNSs are accountable to patients, the nursing profession, and the licensing board to comply with the requirements of the state nurse practice act and related advanced practice nursing rules and regulations. Advanced practice registered nurses are expected to recognize the limits of their knowledge and expertise, and refer patients or consult as needed to provide appropriate quality patient care.

The CNS must be a graduate of an accredited graduate-level education program that specifically prepares the individual for the CNS role (such as acquiring advanced clinical knowledge and skills to provide direct and indirect care to patients). The core CNS

competencies associated with accredited CNS academic programs demonstrate a greater depth and breadth of knowledge, greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy than those identified for the RN. In some states, the CNS must pass a national certification examination that measures both CNS role and population-focused competencies. Certified CNSs in those states must maintain continued competence through recertification by a national certification program.

Social and Professional Mandate for CNS Practice

The role of the CNS was created to meet the increasingly complex and evolving needs of patients and communities. For all nursing roles, and specifically APRN roles, this evolution is based in efforts of the nursing profession to meet their social mandate. A definitive exploration of nursing's ethical framework and social mandate is found in the *ANA Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015). The social mandate for CNS practice is built on this comprehensive and vital social mandate for nursing. The *Code* is a directive for the profession to engage and evolve to meet the demands of society. The CNS role has emerged to meet an important aspect of nursing's obligation to serve society by contributing that for which we are best suited. The growth of nursing's social mandate to include APRN roles is seen internationally.

As a profession, nursing has a social mandate to evolve its practice to meet the needs of the society which creates and supports it. The profession is responsible for helping shape statutes and regulations that impact the role of healthcare delivery and the health of patients and families. Professions are responsible for self-interpretation and self-regulation; therefore, it is imperative that nursing continues to critically self-appraise in the context of contemporary social needs.

Over the past few decades, there have been vast changes in healthcare delivery in the U.S.: the emergence and continued growth of healthcare technologies, changes in reimbursement, and passage of policies that drive reimbursement for healthcare services. Also, we have seen the enduring challenges of providing quality healthcare services to rural and urban underserved populations, the aging and disabled, and patients with multiple chronic conditions. The acuity of patients, the trajectory of hospitalizations, and access to tertiary care services have changed. Over the past few decades there have been healthcare workforce shortages. Numerous national healthcare strategies have attempted to address these issues. The result of these many forces converging on healthcare has resulted in a significant role for APRNs and specifically the role of the CNS in our U.S. healthcare system.

Patients, families, and communities experience societal changes beyond physical health and well-being. Social determinants of health such as employment, safe housing, clean water and air, and adequate nutrition are considered under nursing's social mandate. Assessment and evaluation of those factors on a patient/family or community is a critical aspect of nursing care. Advocacy for societal issues is part of the CNS social mandate.

The CNS role has evolved to provide patients/families and communities with access to certified licensed nursing professionals who have extended and expanded direct patient care skills including extensive experience and knowledge in assessment, planning, implementation, diagnosis, and evaluation. The CNS adds to this expertise through

mentoring, teaching, assessing, and communicating with nurses and other healthcare professionals within their system of care, and integrates their knowledge and skills into system-level change that is based on research and available evidence. The CNS role meets the societal needs for a provider with this high degree of healthcare knowledge, skill, and experience that facilitates optimal outcomes through their critical analysis, problem solving, and evidence-based decision-making.

Another complexity facing the CNS is the increasing diversity and ever-changing cultural backgrounds in our communities. That diversity brings both strengths and challenges. The increase in diversity and cultural backgrounds makes it necessary for CNSs to approach each patient and family as unique and distinct, without assumptions of any cultural or diversity categorization. Through a relationship-centered care foundation, CNSs provide expert care to patients with complex conditions. The relationship with patients and families in the context of their communities is of primary importance, while recognizing that additional relationships, such as those with the interprofessional healthcare team, support a comprehensive approach to optimizing health through reciprocal influences. Clinical nurse specialists advance the health and wellness of these patients by designing innovative evidence-based interventions, setting practice standards, influencing the practice of other nurses, and leading within the healthcare system to improve patient care and support quality outcomes.

Regulatory agencies are mandating that healthcare institutions demonstrate quality outcomes to receive reimbursement for care provided. Concurrently, patients are increasingly aware of the outcomes of individual providers and healthcare institutions. They demand safe, high-quality, individualized, and cost-effective care. This expected evolution and the increased complexity of care is part of the rationale behind the emphasis on the Doctor of Nursing Practice (DNP) degree for all APRNs, including CNSs, to prepare nurses at the highest level of practice to provide advanced care (American Association of Colleges of Nursing [AACN], 2006). The NACNS has called for DNP entry-into-practice for all CNSs by 2030 (NACNS, 2015a). Because CNSs demonstrate mastery in the translation of evidence into nursing practice, CNS leadership in advancing nursing practice as a profession is critically important.

The ANA recognizes CNSs as advanced clinical experts in nursing with attributes distinguishing them from other APRNs; the primary role of the CNS is to continuously improve the nursing care of patients, resulting in improved patient outcomes (ANA, 2010). The ANA acknowledges that while there is an overlap of knowledge and skills among the advanced practice groups, the scope of practice of CNSs is distinguishable from the other APRN groups. Clinical nurse specialists bring a different level of analysis and implementation of emerging nursing science and evidence to the range of care in the wellness-illness continuum including facilitating maintenance of health, prevention, and early detection of illness; diagnosis and treatment of acute illness; management of chronic illness; and optimization of transitions of care.

Clinical nurse specialists integrate scientific evidence to design new interventions that treat symptoms, functional problems, and complications of disease treatment. Regardless of the setting, complications and failure to recover from disease and medical treatment may be prevented by appropriate diagnosis and treatment of illness. Clinical

nurse specialists are skilled at advanced individual patient assessment and development of a treatment plan, but also use their assessment skills to identify overall trends and patterns, using the information to lead quality improvement changes for patients/families and communities as needed. Innovation in illness diagnosis and treatment is one of the hallmarks of CNS practice. Clinical nurse specialists have in-depth advanced knowledge of evidence-based nursing practice within a specialty that results in competencies to:

- Expand the boundaries of nursing practice by focusing on illness management.
- Provide essential, direct care services and therefore reduce the need for additional patient interactions with the healthcare system.
- Advance the practice of other nurses and nursing personnel.
- Develop organizational/system modifications to support and improve patient outcomes and the practice of nursing.

Clinical Nurse Specialists in Relation to Other APRN Roles

Clinical nurse specialists are one of the four APRN groups. This category includes the CNS, CNP, CNM, and CRNA. Clinical nurse specialists are prepared as advanced clinical experts in the diagnosis and treatment of illness, and the delivery of evidence-based nursing interventions (AACN, 2006). They have advanced knowledge of the science of nursing and apply that knowledge to the assessment, diagnoses, interventions, evaluation, and the design of innovations. They function independently to provide theory and evidence-based care to patients in their attainment of health goals.

As noted earlier, the scope of the CNS role ranges from wellness to illness and acute to chronic care. The ICN definition of an advanced practice nurse is a “registered nurse with the expert knowledge, complex decision-making skills, and clinical competencies necessary for expanded practice. This differentiates APRNs from registered nurses (RNs) in that they are capable of taking on more complex casework and handling those cases with greater independence and discretion...” (ICN, 2008). All APRN roles have emerged from a rich tradition of holistic, patient-centered nursing care. In addition, all APRN roles must define how the individual APRN role optimizes advanced nursing expertise while offering the advanced healthcare assessment, diagnosis, and decision-making skills to provide healthcare services, within the scope of practice, that historically may have been provided by physicians.

Taking into consideration the CNS conceptual model that outlines three spheres of impact (see Figure 1), the CNS role is not exclusively focused on the direct patient interface. While the patient/family and community are the key beneficiaries of CNS care, CNSs practice from both an expanded and specialized area of expertise. From an expanded nursing practice perspective, CNSs are skilled at systems thinking to enhance patient/family and community care by identifying gaps, forging and leading collaborative relationships, leading quality improvement efforts, and creating innovative workflows. They work in interprofessional teams and with other nurses to advance nursing practice, including clinical and outcome improvement interventions, and provide clinical expertise to affect system-wide health changes to improve programs of care.

In addition, CNSs are particularly prepared to care for complex and vulnerable patient populations. Consultations with CNSs, when focused on complex and vulnerable

patients, can result in shorter hospital stays and a personalized, multi-focused plan of care that can allow the patient/family to reach healthcare goals. Additionally, addressing the needs of these complex and vulnerable patients/families provides a frame of reference for the CNS to use as a template to intervene and improve nursing and system healthcare for future complex patients and minimize avoidable complications. Because of their expertise in advanced direct patient care, CNSs are in an ideal position to create and implement delivery models to lessen the risks that can occur with transitions of complex patients among multiple specialty and primary care providers and between healthcare settings and home.

APRN Consensus Model and the Clinical Nurse Specialist

Published in 2008 by a group of nursing organization representatives known as the APRN Consensus Work Group, the *Consensus Model for APRN Legislation, Accreditation, Certification and Education* was introduced (APRN Consensus Work Group, 2008). This policy guidance document identifies the four APRN roles—CNS, CNP, CRNA, and CNM—and outlines the core elements that are minimum requirements to be considered an APRN.

The APRN Consensus Model defines a number of terms, including the CNS (see Appendix B for full text of the APRN Consensus Model). This definition is for regulatory purposes and to be considered a starting point in discussing the CNS role.

“The Clinical Nurse Specialist. The CNS has a unique APRN role to integrate care across the continuum and through three spheres of influence² (patient, nurse, system). The three spheres are overlapping and interrelated, but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities” (APRN Consensus Work Group, pp. 8-9, 2008).

This document also provides the key policy foundations for defining any one of the APRN roles including CNSs.

The core criteria required to be considered an APRN are:

- Education in one of the four identified APRN roles.
- Education in at least one of six identified population foci (family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women’s health/gender-related, psych/mental health).
- Education that includes the “3 Ps”: advanced physiology/pathophysiology, advanced health/physical assessment, advanced pharmacology.
- Certification in at least one of the roles and at least one of the population foci through a nationally-accredited program.
- Licensed at the APRN level in at least one of the roles and at least one of the population foci (APRN Consensus Work Group, 2008).

² With the publication of the Third Edition CNS Statement, this phrase is updated to “spheres of impact.”

Specialty Practice and Licensure for the Clinical Nurse Specialist

Consistent with the APRN Consensus Model criteria, CNSs are licensed registered professional nurses with graduate preparation (earned master's or doctorate) from an accredited program that prepares CNSs. They may also be prepared in a post-master's certificate program that is recognized by a national nursing accrediting body as preparing graduates to practice as a CNS. State licensure for the CNS is based on successful completion of a population-foci certification examination.

The NACNS was an active participant in developing the APRN Consensus Model. This regulatory model, endorsed by 48 national nursing organizations, establishes a framework for state licensure and addresses the structured requirements for accreditation, certification, and educational preparation for all four APRN roles. This document was presented by a group of professional nursing membership organizations, accreditors, credentialers, and educators as a new model for APRN licensure that was based on population-level certification. The population-foci identified in the APRN Consensus Model are Family/Individual Across the Lifespan, Adult/Gerontology, Neonatal, Pediatric, Women's Health/Gender-Related, and Psychiatric/Mental Health. At the writing of this document, the APRN Consensus Model was not yet adopted by all states. However, significant changes have been made in accreditation, certification, and education to pave the way for each state to adopt this regulatory model. The National Council on State Boards of Nursing has an initiative to support adoption of the APRN Consensus Model. It posts information on the APRN Consensus Model and maintains maps that articulate the specific progress in adoption of this model by all states (<https://www.ncsbn.org/aprn-consensus.htm>).

One of the hallmarks of CNS practice is the opportunity to specialize in a delimited area of practice based on evidence-based competencies associated with that specialty. This specialization is beyond the population foci certification for licensure. APRN specialties are defined as “a focus of practice beyond role and population focus linked to health-care needs (examples include but are not limited to oncology, older adults, orthopedics, nephrology, palliative care)” (APRN Consensus Work Group, p.10, 2008). Under this model, the CNS would have to obtain state licensure through certification in one of the population foci (for example, Adult/Gerontology, Neonatal, or Pediatric) and then is free to additionally specialize within that population foci (such as oncology, diabetes, cardiology). For example, a CNS would graduate from a program that has national accreditation and offers the core courses as identified above. Graduates select a certification examination (currently there are three options for the CNS): Adult/Gerontology, Neonatal, or Pediatric. Once certified, certificants are eligible for licensure as APRNs in their states (if the state has adopted the APRN Consensus Model).

As noted, one of the changes with the most significant impact on the CNS role is the shift from state licensure based on specialty to state licensure based on population foci. While this is problematic where there are no population-foci certification exams, this approach results in CNSs having more flexibility to expand, enhance, and modify their specialty focus over time. Clinical nurse specialists who practice in states that have adopted the APRN Consensus Model prepare to specialize in additional specialty areas within the population foci. For example, a CNS who begins a career as an

Adult-Gerontology licensed CNS with a specialty in cardiac acute care may evolve his or her practice to a different specialty under the broader population foci umbrella. The CNS might decide to certify in Adult/Gerontology pain management or Adult/Gerontology pulmonary disease management. The CNS will not need to obtain a new license but should pursue and maintain the available specialty credentials for any new practice. While not specified by state license, professional ethics require CNSs to ensure that they engage in the education, certification, and continuing education needed to achieve and maintain proficiency in a specialty.

Specialty areas are developing as the science of healthcare progresses. Typically, a specialty can be identified in terms of the population being cared for, type of patient problem, setting, type of care, and/or disease or medical specialty. Specialties usually address more than a single population, may or may not have practice certifications for basic RN or advanced practice, and can be identified by a national organization or a single entity (such as clinic or hospital grouping). It is important to emphasize that specialty certification exams are to verify one's abilities within a specialty area. They are not considered certification examinations for licensure.

Clinical Nurse Specialists in Relation to Other Nurses with Master's and Doctoral Degrees

The APRN Consensus Model is a significant step in clearly delineating who can be considered an APRN. There continues to be confusion about level of education and preparation required to be considered an APRN. Master's and doctoral degrees are granted for several nursing leadership roles. Those degrees do not necessarily prepare nurses to practice as APRNs. The DNP is a degree, not a role. Only APRNs who obtain a DNP with an APRN role focus can certify and obtain licensure as APRNs.

It is imperative for all nurses and nurse leaders to understand these core elements to accurately appreciate who can practice as an APRN. Some of the expert skills CNSs are prepared for and expected to exhibit (for example, leadership, collaboration, consultation, quality improvement and evidence-based practice, systems thinking, professionalism, and ethical conduct) may be exhibited by other nurses and nurse leaders. Clinical nurse specialists, however, are unique in that they are also prepared in advanced patient care. Therefore, CNSs are prepared and expected to consistently utilize those expert skills within a framework of an advanced direct patient care perspective. This distinctive combination is what distinguishes CNS practice from that of nurse executives, quality improvement specialists, clinical nurse leaders, nurses with a DNP in leadership, or an experienced staff nurse, for example. Therefore, while many registered nurses and nurse leaders may have skill and expertise in some of the competencies outlined in Chapter 3 of this statement, through formal education and clinical experience, it is expected that CNSs are uniquely prepared by higher education to function at this advanced level of nursing practice in all competencies outlined in this document.

Employers should be clear on the advantages of hiring a CNS compared to other nursing leadership roles. The CNS has a nationally recognized, state-specified scope of practice that cannot be replaced by the scope of practice of other APRNs or nurse leaders.

Relationships between Clinical Nurse Specialist Practice, Specialty Knowledge, and Practice Standards

This *Statement* describes the core CNS practice competencies organized by the three spheres of impact and is described in an updated model (Figure 1). In this model, the core competencies are consistent across all CNS practice areas and actualized in population foci and specialty practice. From this point forward, when we refer to “specialty” we are identifying the CNS practice specialty within the selected population foci.

The model in Figure 1 illustrates the relationship of CNS practice, specialty knowledge, and practice standards. The essence of CNS practice is advanced clinical expertise based on advanced knowledge of nursing science; therefore, the patient direct care sphere is depicted as the largest and all-encompassing. Clinical nurse specialist clinical expertise, directed by the specialty, is the basis for competencies in the nurses/nursing practice sphere and the organizations/systems sphere. The context for CNS practice is the specialty. The specialty directs specific knowledge and skill acquisition; thus, the specialty area competencies build on the core CNS competencies in an in-depth area of clinical expertise.

Because CNSs are prepared at an advanced level in all three spheres, activities in one sphere interact with, impact, and enhance activities in the other spheres. Optimal results are achieved when CNS knowledge and function in each sphere synergistically augments the overall outcome. The full impact of the role is exhibited when the CNS functions in and across all three spheres. The unique nature of this APRN role is the ability to be flexible and evolutionary in meeting the healthcare needs of patients in all three spheres. The work, therefore, fluctuates at any given time, depending on the needs of the healthcare system, patient care unit, patient/family, or community. While the spheres intersect and overlap, the direct care sphere is the all-encompassing, overarching focus of the CNS role.

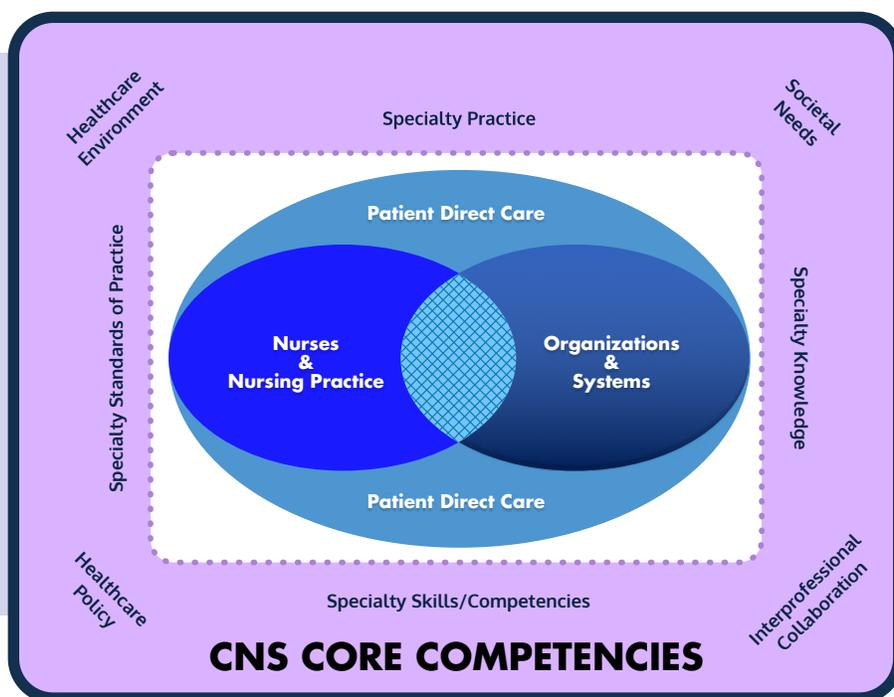


Figure 1.

CNS practice conceptualized as the core competencies in three interacting spheres. The spheres are actualized in specialty practice (population foci/specialty), and guided by specialty knowledge, skills/competencies, and standards of practice. This is within the context of the ever-changing healthcare environment, healthcare policy, interprofessional collaboration, and societal needs. The core competencies are the foundation upon which to build specialty competencies.

Conceptual Model of Clinical Nurse Specialist Practice

Historically, the broad scope of CNS practice was described in terms of sub-roles including expert clinician, educator, researcher, change agent, administrator, and consultant (ANA Council, 1986; Hamric, 1989; Sparacino, 2000). These sub-roles were created at a time when schools of nursing were seeking ways to organize concepts and activities to direct curricula. However, defining CNS practice by sub-roles partitions the skills and activities rather than integrating them. It is the integration and aggregation of those activities that makes CNS practice effective. The CNS role reflects all these sub-roles and is fluid from moment to moment.

While CNS advanced competencies are integrated across the three spheres of impact (patient/family direct care, nurses/nursing practice, and organizations/systems), expert nursing practice in the patient/family sphere provides the underpinnings for advanced practice. Thus, the model for CNS practice, as articulated in this and the original *Statement* (NACNS, 2004) is based on the position that CNS practice is consistently targeted at achieving quality, evidence-based, and cost-effective outcomes through advanced, specialized patient care. In addition, the CNS also influences the practice of other nurses and healthcare personnel and the healthcare organization/system to support nursing practice through advanced specialty clinical expertise, advocacy, consultation, collaboration, scholarship, and leadership. Clinical nurse specialists are effective advocates due to their advanced knowledge and expertise in all three spheres of impact. The CNS is a consultant for complex patient problems, staff knowledge, performance assessment and enhancement, program development, professional practice and best-practice model development and implementation, system change strategies, and professional development. As a content expert, the CNS suggests a wide range of alternative and innovative approaches to clinical or systems problems.

Elements of the model are interactive and collectively determine the scope or breadth of practice activities within and across the spheres. It is important to keep in mind that the scope of the CNS role ranges from wellness to illness and acute to chronic care. The experience a CNS has with expert direct patient interactions provides a frame of reference and credibility for expert practice in the other spheres of practice. This allows the CNS to optimize patient outcomes in all CNS Practice Spheres. The core competencies for each sphere of impact and associated outcomes are presented in Chapters 3 and 4.

Clinical Nurse Specialist Practice: Patient Direct Care Sphere

Clinical nurse specialists have advanced knowledge and skills beyond the RN role to assess, diagnose, and treat illness (ICN, 2008). The CNS performs evidence-based assessment and treatment of illness including symptoms, functional problems, and risk behaviors. The CNS is educated and skilled in comprehensive assessment, differential diagnosis, and interventions to prevent or treat illness. Clinical nurse specialists use advanced communication skills in complex situations and conversations that might be unpredictable while caring for patients throughout the health continuum. Patients may seek or need the care of CNSs to prevent, alleviate, or minimize illness or alter risk behaviors. The CNS may intervene to educate, guide, and coach the patient in modifying risk behaviors, and emphasizing health-promoting lifestyles. The CNS leads discovery of innovations in patient care using nursing science, theory, and knowledge generated by nursing and related disciplines.

Box 1. Patient Direct Care Sphere Examples

Because the individual CNS works in different clinical situations, examples of direct care have been identified below for clarity. This is not intended to be an exhaustive list, but instead to highlight examples of various patient direct care sphere activities that require the expert knowledge, complex decision-making skills, and clinical competencies necessary for expanded practice as a CNS.

Depending on how the CNS works in private practice, primary and/or ambulatory care, or as a healthcare system employee, these direct care interactions may be eligible for direct reimbursement to the CNS provider. Clinical nurse specialists are encouraged to explore direct reimbursement opportunities that may be available in states, facilities, and from federal and private insurers.

- Perform consultation with nurses related to complex patient care involving advanced assessment and interaction with the patient.
- Prepare and coordinate care transitions for complex patients that include direct assessment of the patients and families' preferences, needs, and resources.
- Lead development of care plans for complex chronically ill patients who have frequent hospital readmissions in collaboration with patients, families, healthcare providers, and appropriate community resources.
- Coordinate care among multiple healthcare providers and assure that there is clear communication with patients/families/healthcare team.
- Teach parents how to care for and manage their child's complex (e.g., cystic fibrosis and diabetes) medication regimen and enteral feeding plan, and assess placement and operation of a feeding tube.
- Assess and provide skin markings for ostomy placement before a patient's surgery.
- Order physical restraints for a patient based on advanced assessment skills and prescriptive authority.
- Lead conversation with a patient and family regarding disease education, goals of care, and end-of-life and advance directive decision-making.
- Provide well-child assessments, school physicals, and interventions in primary care clinics.
- Assess and provide complementary therapies for an adult or child who has had adverse responses to pain medications and is experiencing significant post-operative pain.
- Order laboratory tests and X-rays for diagnostic interpretation after assessment of a new patient who arrives at the Emergency Department.
- Facilitate a meeting among a patient, family, and healthcare providers for decision-making to address complex ethical care components.

- Prescribe appropriate medications and treatments for a complex patient with diabetes.
- Perform home visits to palliative care patients and assess the effectiveness of their home care plan and the safety of the home care environment. Prescribe pharmacologic and non-pharmacologic measures to improve the patient's and family's comfort.

Clinical Nurse Specialist Practice: Nurses and Nursing Practice Sphere

The CNS advances nursing practice and improves patient outcomes by ensuring that nurses and nursing personnel utilize evidence-based practices to support patients and families during acute care and in transitions from acute care settings to home and community environments. The CNS develops population profiles and conducts clinical inquiries to determine the need to change practice. The CNS exerts influence through role modeling, consultation, and education with other nurses and healthcare providers to improve nursing practice and patient outcomes. The CNS is a skilled communicator and educator with expert skills. The CNS listens, validates, reflects, provides constructive feedback, and supports the nurse and nursing team. The CNS creates and develops evidence-based policies, procedures, and protocols, and best practice models/guidelines using advanced clinical and specialty knowledge. The CNS assists nurses and the interprofessional team to evaluate and change practice standards and ensure that nursing practice is evidence-based.

Box 2. Nurses and Nursing Practice Sphere Examples

Because CNSs work in different healthcare systems and have varied job responsibilities, the following nurse and nursing practice sphere activities are provided as examples. This is not intended to be an exhaustive list, but rather to highlight ways the CNS's expert knowledge, complex decision-making skills, and clinical competencies support the expanded practice role of the CNS in relation to the nurse and nursing practice sphere.

Depending on how the CNS works in private practice or as an employee in tertiary care facilities, these nurse and nursing practice sphere interactions may directly affect staff nurse acquisition of knowledge and skills that would impact the quality and outcomes of care of different patient populations.

- Consult to review a unit's issues related to a newly implemented program to prevent patient falls. Identify, plan, and implement a program to assist staff nurse engagement individualized to their specific needs.
- Collaborate with the clinical educator to develop orientation for newly-hired nurses to specific patient care units.
- Serve as a preceptor for CNS students in the role of primary care provider for cardiac patients in community clinics.

- Assess, plan, and develop an education plan specific to new technology adoption in a specialty that takes into account the learning styles of the clinical nursing staff.
- Role model how to conduct an effective patient palliative care conference to provide nursing staff the resources needed to assist their patients and families.
- Present at local, state, and national conferences to articulate specialty knowledge.
- In collaboration with community disaster planning experts, plan a disaster drill for their facility with a specific emphasis on the contribution of nurses.
- Conduct clinical consultation, including coaching with bedside nurses, regarding performance of complex patient care interventions.
- Lead a nursing evidence-based practice committee to facilitate the process of translating evidence into practice.
- Mentor nurses in their professional development through experiences available at the healthcare facility, school of nursing, and/or community.

Clinical Nurse Specialist Practice: Organizations/Systems Sphere

The third sphere of CNS impact—the organization and system level—is critically important because of the evolving complexity of healthcare. The CNS is positioned to articulate the value of the nurse’s contribution to healthcare outcomes at the organizational and/or decision-making level, and advocates for professional nursing. The CNS influences the trajectory of care, from admission through discharge to home, to assist the patient in achieving desired outcomes after discharge and minimize recidivism and readmission. In some situations, the CNS works system-wide across multiple facilities in a healthcare system. The CNS’s advanced assessment, diagnostic, and collaboration skills coupled with advanced knowledge of systems, safety, research, and quality allow the CNS to facilitate projects and policy changes, and enhance patient outcomes as they transition across care settings. To enhance the abilities of patients and their families to manage care at home, the CNS leads nursing and interprofessional groups to implement innovative patient-centered care programs that address patient needs across the continuum of care.

The CNS leads systematic quality improvement and safety initiatives based on gap assessments and data analysis to improve nursing practice for safe, high-quality, and cost-effective patient outcomes. The CNS drives translation of best evidence into practice and facilitates integration of multiple programs and disciplines across the healthcare system to ensure positive patient outcomes. The CNS collects and analyzes patient data to document the impact of nursing practice on outcomes, efficiency, and cost-effectiveness. The CNS has proficiency in collaborative systems thinking to determine what is working well, and what requires intervention to best predict and achieve quality, cost-effective patient care and outcomes. The CNS interacts with government and regulatory agencies, healthcare insurers, community leaders, and consumers to assure access to healthcare services and safe, competent nursing care. The CNS is concerned with

creating healthy communities and works to enhance the culture of health beyond the healthcare system. In addition, CNSs use their expert leadership skills individually and through their professional organizations to influence policymakers and advocate for equitable healthcare. It is suggested that CNSs participate as members and leaders in their state nurses' associations, specialty nursing/healthcare associations, and NACNS.

Box 3. Organizations/Systems Sphere Examples

Because the individual CNS works in different healthcare systems and has varied job responsibilities, these activities in the organizations/systems sphere are provided below as examples. This is not intended to be an exhaustive list, but instead to highlight how the CNS's expert knowledge, complex decision-making skills, and clinical competencies support the expanded practice role of the CNS in relation to the organizations/systems sphere.

Depending on the CNS practice setting and advocacy work, these organizational and system sphere activities may directly or indirectly affect change at a clinic, hospital, or health system level and/or at local, state or federal policy levels.

- Lead a quality improvement initiative for the identification and treatment of patients with *c. difficile* infection across a healthcare system.
- Lead a team to pursue a healthcare facility's Magnet® journey.
- Assess, plan, and implement team-based strategies to reduce the average length of stay of lumbar spine trauma patients based on current benchmarks and best evidence.
- Lead and/or collaborate with an interprofessional team to implement a new adult malnutrition assessment throughout the system.
- Design a model of professional nursing care visits in collaboration with the home healthcare team.
- Innovate and implement a crisis psychiatric/mental health CNS team to optimize best practices for unplanned hospitalizations of psychiatric/mental health patients.
- Collaborate with interprofessional team members to implement new evidence-based guidelines related to the treatment of patients with diabetes in the primary care setting.
- Lead an initiative to determine the cost-benefit analyses of newly available patient care technology considering the clinical benefit of the decision.
- Lead an initiative to reduce noise in the patient care environment while maintaining high safety standards for individual patients.
- Advocate to state and federal legislators about the need for telehealth to manage the ongoing cardiac care needs of chronic heart failure patients in rural and frontier areas.

- Advocate to legislators and regulators for the importance of the CNS full scope of practice to improve healthcare access for patients/families and communities.
- Collaborate with community housing advocacy groups and state and local government to improve housing options for pregnant women in the community.

Legislative and Regulatory Issues Related to Clinical Nurse Specialist Practice

Clinical nurse specialists are licensed registered professional nurses who are educated at the graduate level as CNSs to practice nursing at an advanced level. Regulation of CNS practice includes title protection explicated in law and scope of practice delineated in regulations. The RN license authorizes autonomy in the diagnosis and treatment of health-related problems amenable to nursing interventions and the authority to execute medical regimens. The CNS role builds on the nursing scope of practice and also includes expansion of the nursing role in the development of those skills. The advanced practice role includes the autonomous authority to assess, diagnose, and initiate orders for treatment and therapy to include prescriptive authority for pharmacologic and non-pharmacologic therapies (APRN Consensus Work Group, 2008). That practice is based on the CNS's direct care expertise and advanced knowledge and skills as expressed in the CNS core competencies in this *Statement*.

Clinical nurse specialist education prepares graduates to expand the practice of nursing through application of knowledge and development of advanced clinical competencies. Clinical nurse specialists are also responsible for certain medical interventions as they apply knowledge and develop skills related to the methods, techniques, and management of certain patient care therapies. To optimize access to healthcare for all U.S. residents, CNSs should be allowed to work at the full scope of their practice. In the direct care realm that includes, but is not limited to, prescriptive authority; signature authority; and prescribing of laboratory, X-ray, and durable medical equipment. Clinical nurse specialists will vary in their need to utilize all aspects of this scope of practice depending on their employment settings, reimbursement expectations, and specialties.

To achieve full scope of practice for the CNS, CNSs may have to engage in advocacy at the state level to change laws and/or regulations. One key initiative is to seek title protection for CNSs. A statute granting title protection should specify that those who use the CNS title must meet the APRN Consensus Model definition of an APRN. Lack of title protection in a state can result in misuse of the title by those without graduate preparation and can be misleading to the public. Clinical nurse specialists must be legally designated for regulation by the state boards of nursing. State practice acts should also specify the full scope of practice of the CNS and defer the regulation of this aspect of practice to the boards of nursing.

Many states are pursuing changes in their scope of practice to allow the state to implement aspects of the APRN Consensus Model. If implemented fully, it includes title protection, prescriptive authority, grandfathering, and other privileges. Because of the

changes in licensure that comes with the APRN Consensus Model implementation, it is critical that state legislators recognize the contribution of practicing CNSs and include appropriate grandfathering language in legislation where needed.

The scope of CNS practice should be explicated in legislation and regulation written by state or federal entities. The CNS scope of practice should reflect that CNSs are recognized and held accountable for their advanced clinical knowledge. Requirements for entry into practice, grandfathering of CNSs, title protection parameters, and prescriptive and signature authority conditions may be defined in regulation. Requirements for licensure for practice will also be articulated in either or both legislation and regulation. In the case of implementation of the APRN Consensus Model, states will identify certification examinations at the population foci level for licensure.

Other legislative and regulatory priorities involve creating statutes that allow for full scope of practice of the CNS. States vary in how they approach what practice activities are included in legal statutes and which ones are under regulation. While an individual can make progress in setting the stage for such changes, most CNSs find that a coalition of APRNs and patient advocacy groups is more successful in promoting legislative and regulatory changes. Information on current and impending legislative and regulatory issues can be identified through your state nurses' association, specialty association, or NACNS and its affiliate organizations.

Professional Validation of Clinical Nurse Specialist Competencies

Validation of practice competency and expertise is the responsibility of professional organizations. Validation should be consistent with the specialty focus of the professional organization. The NACNS supports a wide variety of initiatives by professional organizations to validate practice competencies of CNSs. Professional validation must include the core competencies for CNS practice as actualized in population foci and specialty practice. The NACNS supports various methods for validating competencies. This competency validation may occur at various time points in a CNS's career, including entry into practice and periodic re-evaluation through certification or other measures of continued competence. Evidence used for validation of continuing competencies may include continuing education, psychometric examination, portfolio review, publication, research activities, or other evidence or combinations of evidence determined appropriate for the specialty by the professional organization.

Validation of competencies should match the population foci and specialty focus of CNS practice. Validation of broad competencies or competencies in related content or practice areas do not attest to specialty competency.

CHAPTER 3

Clinical Nurse Specialist Core Competencies

INTRODUCTION

The core CNS competencies are the foundation of CNS practice in a complex and evolving healthcare system. They are the comprehensive, entry-level competencies and behaviors expected of graduates of all programs (master's or DNP level) that prepare CNSs. Because of the wide range of specialties in which CNSs practice, the core competencies reflect CNS practice across all population foci, specialties, and settings. Fundamental to the competencies is that the CNS maintains state licensure and/or designation as an APRN, is certified as a CNS in one of the six approved population foci, and has completed a course of education as a CNS in an accredited program (NACNS, 2010).

Domains of the Core Competencies

The core competencies in this statement align with the domains or categories used in the preparation of the 2010 *Clinical Nurse Specialist Core Competencies* (NACNS, 2010) and the domains used in the 2017 *Common APRN Doctoral-Level Competencies and Progression Indicators* (AACN, 2017). The latter adopted the Common Taxonomy for Competency Domains in the Health Professions (Englander et al., 2013). For example, within the patient direct care sphere of impact, the first competency is: Uses relationship-building communication to promote health and wellness, healing, self-care, and peaceful end-of-life. This aligns with Direct Care from the 2010 document and with the Domain of Interpersonal and Communication Skills in correlation with the *Common APRN Doctoral-Level Competencies*. The Task Force ensured these resources were reviewed to confirm that the competencies reflect relevant domains used in the past and contemporary domains that promote interprofessional practice.

Conceptual Framework: Core Competencies by Spheres of Impact

The three spheres of impact provide an organizing framework to describe core CNS competencies. The competencies represent essential skills used to achieve desired outcomes in CNS practice. A CNS may focus on any one or all of the three spheres of CNS practice, but clinical expertise in the patient direct care sphere remains the core of CNS practice for each of the other two spheres. The competencies are used in other spheres to influence nurses, nursing practice, and organizations and systems to improve patient outcomes, provide cost-effective care, and advance clinical practice. Deliberative CNS practice, partnering with colleagues from other disciplines, ensures that desired patient outcomes will be attained.

Table 1
CORE CLINICAL NURSE SPECIALIST COMPETENCIES

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.

COMPETENCIES – PATIENT DIRECT CARE SPHERE	
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, including cost and clinical effectiveness, on patient and family values and preferences.
P.16	Advocates for patient's preferences and rights.

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.

COMPETENCIES – NURSES AND NURSING PRACTICE SPHERE	
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.
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.

Organizations/Systems:

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.

COMPETENCIES – ORGANIZATIONS/SYSTEMS SPHERE	
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 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 (i.e., 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 the public.
O.12	Promotes nursing's unique contributions to advancing health to stakeholders (e.g., the organization, community, public, and policymakers).
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.

CHAPTER 4

Outcomes of Clinical Nurse Specialists

INTRODUCTION

The outcomes of CNSs' practice were first published in the 2004 statement (NACNS, 2004). The extensive annotated bibliography of research studies and articles about CNS practice and outcomes by Kathleen Baldwin, PhD, RN, FAAN and NACNS has been archived with NACNS. In 2015, a descriptive study was conducted by Fulton et al. "to assess CNSs' perceptions of the ongoing validity of outcomes published by the National Association of Clinical Nurse Specialists" (Fulton, Mayo, Walker, & Urden, 2016). The findings of the study demonstrated agreement with identified outcomes and current CNS practice.

Conceptual Framework: Outcomes of Clinical Nurse Specialists by Spheres of Impact

The validated outcomes of CNS practice have been reviewed by the Task Force to ensure alignment with the core competencies. Each competency within each sphere has an associated outcome. That provides for confidence in the relevance and importance of the individual competencies within the framework of the spheres of impact.

Table 2
OUTCOMES OF CLINICAL NURSE SPECIALISTS
Definitions

PO = Patient Outcome | **NO** = Nurse Outcome | **OO** = Organization Outcome

OUTCOMES – PATIENT DIRECT CARE SPHERE	
PO.1	Phenomena of concern requiring nursing interventions are identified.
PO.2	Diagnoses are accurately aligned with assessment data and etiologies.
PO.3	Plans of care are appropriate for meeting patient needs with available resources, reflecting patient/family treatment preferences and shared decision-making.
PO.4	Nursing interventions target specified etiologies.
PO.5	Programs of care are designed for specific populations (e.g., oncology, specific ethnic groups, end-of-life).
PO.6	Prevention, alleviation, and/or reduction of symptoms, functional problems, or risk behaviors are achieved.
PO.7	Nursing interventions, in combination with interventions by members of other disciplines, result in synergistic patient outcomes.
PO.8	Unintended consequences and errors are prevented.
PO.9	Predicted and measurable nurse-sensitive patient outcomes are attained through evidence-based practice.

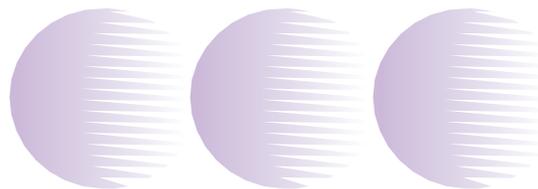
PO.10	Interventions have measurable outcomes that are incorporated into guidelines for practice with deletion of inappropriate interventions.
PO.11	Collaboration with patients/families, nursing staff, physicians, and other healthcare professionals occurs as appropriate.
PO.12	Desired measurable patient outcomes are achieved. (Desired outcomes of care may include improved clinical status, quality of life, functional status, alleviation or remediation of symptoms, patient/family satisfaction, and cost-effective care.)
PO.13	Innovative educational programs for patients, families, and groups are developed, implemented, and evaluated.
PO.14	Transitions of patients are fully integrated across the continuum of care to decrease fragmentation.
PO.15	Reports of new clinical phenomena and/or interventions are disseminated through presentations and publications.
PO.16	Interventions that are effective in achieving nurse-sensitive outcomes are incorporated into guidelines and policies.

OUTCOMES – NURSES AND NURSING PRACTICE SPHERE

NO.1	Knowledge and skill development needs of nurses are delineated.
NO.2	Evidence-based practices are used by nurses.
NO.3	The research and scientific base for innovations is articulated, understandable, and accessible.
NO.4	Nurses can articulate their unique contributions to patient care and nurse-sensitive outcomes.
NO.5	Nurses are empowered to solve patient care problems at the point of service.
NO.6	Desired patient outcomes are achieved through the synergistic effects of collaborative practice.
NO.7	Nurses' career enhancement programs are ongoing, accessible, innovative and effective.
NO.8	Nurses experience job satisfaction.
NO.9	Nurses engage in learning experiences to advance or maintain competence.
NO.10	Nurses use resources judiciously to reduce overall costs of care and enhance the quality of patient care.
NO.11	Competent nursing personnel are retained because of increased job satisfaction and career enhancement.
NO.12	The impact of implicit bias on relationships and outcomes is recognized and minimized.
NO.13	Educational programs that advance the practice of nursing are developed, implemented, evaluated, and linked to evidence-based practice and effects on clinical and fiscal outcomes.
NO.14	Nurses have an effective voice in decision-making about patient care.

OUTCOMES – ORGANIZATIONS/SYSTEMS SPHERE

OO.1	Clinical problems are articulated in the context of the organization/system structure, mission, culture, policies, and resources.
OO.2	Patient care processes reflect continuous improvements that benefit the system.
OO.3	Change strategies are integrated throughout the system.
OO.4	Policies enhance the practice of nurses individually as members of multidisciplinary teams.
OO.5	Innovative models of practice are developed, piloted, evaluated, and incorporated across the continuum of care.
OO.6	Evidence-based, best practice models are developed and implemented.
OO.7	Nursing care and outcomes are articulated at organizational/system decision-making levels.
OO.8	Stakeholders (nurses, other healthcare professionals, and management) share a common vision of practice outcomes.
OO.9	Decision-makers within the institution are informed about practice problems, factors contributing to the problems, and the significance of those problems with respect to outcomes and costs.
OO.10	Patient care initiatives reflect knowledge of cost management and revenue enhancement strategies.
OO.11	Patient care programs are aligned with the organization's strategic imperatives, mission, vision, philosophy, and values.
OO.12	Staff comply with policies, protocols, and standards of care that reflect regulatory requirements and standards.
OO.13	Policy-making bodies are influenced to develop regulations/procedures to improve patient care and health services.



CHAPTER 5

Recommendations for Graduate Preparation of Clinical Nurse Specialists

INTRODUCTION

This section presents recommendations for graduate preparation of CNSs necessary for the acquisition of CNS core competencies. The curricular content areas were derived from a review of the literature, feedback from practicing CNSs, and review of educational standards (AACN, 2006; AACN, 2011). It is important to note that curriculum for population-specific and specialty practice competencies is beyond the scope of these recommendations. For both, national standards articulated by specialty organizations should be used to develop additional courses, content areas, or educational learning threads as needed. The recommendations in this section are designed to provide guidance to CNS educators as they evaluate, revise, or develop CNS programs. They may also be used to guide current CNSs in practice as they continue their professional development.

History and Evolution of Clinical Nurse Specialist Education

In direct response to the National League for Nursing's recommendations for universities to develop master's level nursing curricula, Peplau and Reiter proposed the psychiatric CNS role in the 1940s as a model of advanced clinical nursing (Fulton, 2014; Peplau, 1965/2003; Reiter, 1966). The first CNS program began at Rutgers University in 1954, heralding a fundamental shift in education for nurses away from the culture of hospital-based diploma education to university-based education leading to specialty practice knowledge through the integration of theory and science (Fulton, 2014; Mick & Ackerman, 2002). Clinical nurse specialist education was developed to prepare CNSs as expert clinical nurses, providing specialized nursing care directly to patients, and indirectly improving care by focusing on nursing staff education and system analysis (Boyd et al., 1991; Fenton, 1985; Page & Arena, 1994).

By 1980, there were multiple programs for CNS education, and early evaluation research validated the innovative contributions of CNS care (Bigbee & Amidi-Nouri, 2000; Georgopoulos & Christman, 1970; Georgopoulos & Jackson, 1970). In the 1980s, some nursing leaders suggested that reconfiguring the curricula and coalescing the CNS, NP, and CNM roles into a single advanced practice nursing role was a way to gain political clout and position nurses as a major provider of primary care (Schroer, 1991). The proposal for a single title, however, generated significant debate within the profession (Sparacino, 2000) and was abandoned because the unique contributions of each group were lost.

In the 1990s, there was variability in CNS education requirements across the country (Fulton, 2014; Walker et al., 2003). Surveys of graduate nursing programs that prepared CNSs, NPs, and CNMs in the U.S. revealed significant variations in the length of programs, number of courses in the major, specialty titling, and competencies (AACN, 1994; Burns et al., 1993; Walker et al., 2003). Those findings, with changes in the healthcare system and debate within the nursing community concerning the requisite

knowledge for nursing at the advanced level, led to the publication of several position statements. The statements provided direction for advanced preparation by recommending changes in the regulation of health professionals (Pew Health Professions Commission, 1995), delineating the scope and standards of advanced practice nursing (ANA, 1996; ANA, 2004), and providing guidelines for graduate preparation of advanced practice nurses (AACN, 1996).

The AACN's *Essentials of Master's Education for Advanced Practice Nursing* (1996) filled a gap by offering guidance for curricular development in graduate programs. The document said graduates of master's programs in nursing must have "critical thinking and decision-making skills... ability to critically and accurately assess, plan, intervene, and evaluate the health and illness experiences of clients... ability to communicate effectively... (and) the ability to analyze, synthesize, and utilize knowledge" (p. 6).

The NACNS has published two documents to provide additional guidance for CNS education. In 1998, NACNS published its first statement on CNS practice and education. After just three years, 56 percent of CNS education programs were using the 1998 NACNS recommendations to guide their curricula (Walker et al., 2003). The NACNS published a second edition of education recommendations in 2004. The recommendations in that document build on the two previously published statements.

In 2008, CNS education was further standardized by publication of the *Consensus Model for APRN Licensure, Accreditation, Certification, and Education* (APRN Consensus Work Group, 2008). That document has since been used by certification bodies to guide certification eligibility criteria and by state boards of nursing to regulate advanced practice. Because the document outlined requirements for three separate courses focused on advanced pathophysiology, pharmacology, and physical assessment, these courses are now standard in all CNS programs. Additionally, the document included National Council of State Boards of Nursing (NCSBN) criteria that certification bodies require at least 500 supervised practicum hours. Therefore, to ensure that CNS graduates were eligible to take post-graduation certification examinations, CNS programs had to include at least 500 precepted practicum hours regardless of specialty. The requirements in the Consensus Model continue to drive regulation and certification requirements.

The Consensus Model (APRN Consensus Work Group, 2008) provided clarity related to the four roles of advanced practice: CNS, CNP, CNM, and CRNA. The document established that APRN education would lead to preparation in one of those four roles, with further preparation in a population, of which there are six. They include "family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health" (APRN Consensus Work Group, 2008, p. 5). Unfortunately, there are not CNS certification exams for all populations. As of 2018, the American Nurses Credentialing Center (ANCC) offers one CNS-specific certification examination: Adult-Gerontology (ANCC, 2018). The American Association of Critical Care Nurses offers CNS certification exams in adult-gerontology, pediatrics, and neonatal (American Association of Critical-Care Nurses, 2018). Because certification exams are not available for all populations, CNS education programs will need to focus on those areas in which certification exams exist.

As stated in Chapter 1 of this document, competencies listed in Chapter 2 are role-based and do not address population foci or specialties. Similarly, the education recommendations in this section are also CNS role-based. Additional population foci and specialty education recommendations will need to be built on population foci and specialty competencies.

These national documents provide a general framework for preparing nurses at a master's or an advanced practice level. The Essentials documents are broad and include core content and learning outcomes that apply across roles and specialties (AACN, 2006; AACN, 2011). It is therefore important to outline CNS-specific content that ensures achievement of core competencies upon graduation from master's or practice doctorate CNS programs.

Curricular Recommendations

As previously stated in Chapter 1 of this document, the competencies contained in Chapter 2 apply to two levels of entry for CNS practice: Master's and DNP. We recognize that multiple competency sets exist that can also be used to create CNS curricula; for example, Interprofessional Education Collaborative (IPEC) (IPEC, 2016) and Quality and Safety Education for Nurses (QSEN) (AACN & QSEN, 2012). In this document, our discussion is limited to commonly used curriculum statements, as opposed to competencies. For an example of QSEN curriculum alignment in the practice setting, see Altmiller (2011). For curriculum alignment with IPEC, see Mayo and colleagues (2016).

The NACNS recommends the following curricula content for CNS education:

1. Use AACN's *Essentials for Master's* (2011) and *Doctoral Education for Nursing Practice* (2006) to address core education requirements. As previously stated, neither document is specific to CNS practice.
2. Required courses in advanced pathophysiology and pharmacology should include the following content for CNS education:
 - a. Advanced physiology/pathophysiology should also include advanced science content such as epidemiology, psychobiology, and genetics. Advanced science content should include concepts and principles relevant for CNS practice, reflect a balance between illness and disease etiologies, and be integrated throughout the curriculum.
 - b. In addition to performing advanced physical assessment, coursework must emphasize the evaluation of the continuum of wellness to illness (including health promotion and disease prevention); psychosocial, functional, and environmental factors; and risk behaviors to support the ability to make differential diagnoses.
 - c. Advanced pharmacology should include principles of pharmacodynamics, pharmacokinetics, pharmacotherapeutics, pharmacogenomics, and drug-drug and drug-food interactions. Where a state may require additional preparation for prescriptive authority, the advanced pharmacology course(s) should meet statute requirements.

- 3.** The NACNS recommends the following additional core content specific to CNS practice (a description of each content area follows):
- Theoretical and empirical foundations for CNS practice.
 - Theoretical and empirical knowledge of phenomena of concern that forms the basis for assessment, diagnosis, and treatment of illness and wellness within the CNS population and specialty.
 - Theoretical and scientific base for the design and development of innovative evidence-based nursing interventions and programs of care.
 - Clinical inquiry/critical thinking with advanced knowledge.
 - Selection, use, and evaluation of healthcare technology/products/devices.
 - Theories of teaching, mentoring, and coaching for use in all three spheres of impact.
 - Influencing change.
 - Systems thinking regarding the organizational culture.
 - Leadership for interprofessional collaboration.
 - Consultation theory.
 - Quality improvement and safety.
 - Measurement and outcome evaluation methods.
 - Evidence-based practice and knowledge translation.
 - Interpersonal communication and leadership.
 - Advocacy and ethical decision-making.

The following table shows the alignment of the core CNS competencies with CNS outcomes, and curriculum content recommendations.

Table 3
ALIGNMENT OF COMPETENCIES, OUTCOMES,
AND CURRICULAR RECOMMENDATIONS

Definitions

PO = Patient Outcome | *NO* = Nurse Outcome | *OO* = Organization Outcome

Patient:

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

Direct Care:

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

Nurses and Nursing Practice:

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

Organizations/Systems:

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.

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
PATIENT DIRECT CARE SPHERE OF IMPACT		
<p>P.1 Uses relationship-building communication to promote health and wellness, healing, self-care, and peaceful end-of-life.</p>	<p>PO.11 Collaboration with patients/families, nursing staff, physicians, and other healthcare professionals occurs as appropriate.</p>	<p>Theoretical foundations for CNS practice include theories, conceptual models, and research-based evidence that shape the CNS perspective. Content includes theories of health, illness, wellness, learning, stress, and palliative care.</p> <p>Relationship-based communication, conflict management, crucial conversations, peer feedback, awareness of implicit bias, embracing diversity, and shared decision-making with patients and significant others.</p>
<p>P.2 Conducts a comprehensive health assessment in diverse care settings including psychosocial, functional, physical, and environmental factors.</p>	<p>PO.1 Phenomena of concern requiring nursing interventions are identified.</p>	<p>In addition to performing advanced physical assessment, coursework must emphasize the evaluation of wellness, illness, psychosocial, functional and environmental factors as well as risk behaviors to support the ability to make differential diagnoses.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>P.3 Synthesizes assessment findings using advanced knowledge, expertise, critical thinking, and clinical judgment to formulate differential diagnoses.</p>	<p>PO.1 Phenomena of concern requiring nursing interventions are identified.</p> <p>PO.2 Diagnoses are accurately aligned with assessment data and etiologies.</p> <p>PO.8 Unintended consequences and errors are prevented.</p>	<p>Critical thinking, diagnostic reasoning, pattern identification, clinical decision-making, and problem-solving strategies.</p>
<p>P.4 Designs evidence-based, cost-effective interventions, including advanced nursing therapies, to meet the multifaceted needs of complex patients.</p>	<p>PO.3 Plans of care are appropriate for meeting patient needs with available resources, reflecting patient/family treatment preferences and shared decision-making.</p> <p>PO.5 Programs of care are designed for specific populations (e.g., oncology, specific ethnic groups, end-of-life).</p>	<p>Theoretical and empirical knowledge of illness and wellness phenomena with non-disease and disease-based etiologies. Examples of phenomena include symptoms (e.g., nausea, fatigue, pain, dyspnea), cognitive impairment, dementia, iatrogenesis, developmental delay, end-of-life/dying, environmental hazards, impaired mobility, ineffective coping, impaired wound healing, safety, sleep disturbances, unsafe workplace, and workplace violence.</p>
	<p>PO.8 Unintended consequences and errors are prevented.</p> <p>PO.16 Interventions that are effective in achieving nurse-sensitive outcomes are incorporated into guidelines and policies.</p>	<p>The design and development of nursing assessments, evidence-based interventions, and programs of care. The content includes validating existing practices and identifying the need for innovations. This knowledge area also includes the theoretical and scientific basis for the selection and use of specific nursing assessment instruments and interventions and is the basis for nursing innovation.</p>
<p>P.5 Implements customized evidence-based advanced nursing interventions, including the provision of direct care.</p>	<p>PO.4 Nursing interventions target specified etiologies.</p> <p>PO.8 Unintended consequences and errors are prevented.</p> <p>PO.16 Interventions that are effective in achieving nurse-sensitive outcomes are incorporated into guidelines and policies.</p>	<p>Theoretical and empirical knowledge of illness and wellness phenomena with non-disease and disease-based etiologies.</p> <p>The design and development of nursing assessments, evidence-based interventions, and programs of care. The content includes validating existing practices and identifying the need for innovations. This knowledge area also includes the theoretical and scientific basis for the selection and use of specific nursing assessment instruments and interventions and is the basis for nursing innovation.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>P.6 Prescribes medications, therapeutics, diagnostic studies, equipment, and procedures to manage the health issues of patients.</p>	<p>PO.4 Nursing interventions target specified etiologies.</p> <p>PO.7 Nursing interventions, in combination with interventions by members of other disciplines, result in synergistic patient outcomes.</p>	<p>Advanced pharmacology that includes principles of pharmacodynamics, pharmacokinetics, pharmacogenomics, and, drug-drug, and drug-food interactions pertinent to the specialty. In situations in which the CNS desires prescriptive authority, an advanced pharmacology course should meet statute requirements.</p>
<p>P.7 Designs and employs educational strategies that consider readiness to learn, individual preferences, and other social determinants of health.</p>	<p>PO.3 Plans of care are appropriate for meeting patient needs with available resources, reflecting patient/family treatment preferences and shared decision-making.</p> <p>PO.13 Innovative educational programs for patients, families, and groups are developed, implemented, and evaluated.</p>	<p>Theories and evidence about the factors that influence learning, health behaviors, and the teaching and coaching of learners who are patients and their significant others. Examples of content include assessing learning needs, designing health messages and health education materials to match literacy ability, cultural diversity, and physical capability; using theories and evidence to design teaching strategies to enhance learning.</p>
<p>P.8 Uses advanced communication skills in complex situations and difficult conversations.</p>	<p>PO.8 Unintended consequences and errors are prevented.</p> <p>PO.11 Collaboration with patients/families, nursing staff, physicians, and other healthcare professionals occurs as appropriate.</p>	<p>Relationship-based communication, conflict management, crucial conversations, peer feedback, awareness of implicit bias, embracing diversity, and shared decision-making with patients and significant others.</p>
<p>P.9 Provides expert consultation based on a broad range of theories and evidence for patients with complex healthcare needs.</p>	<p>PO.11 Collaboration with patients/families, nursing staff, physicians, and other healthcare professionals occurs as appropriate.</p>	<p>Consultation theory and research, and the associated process skills of serving as a clinical expert consultant.</p>
<p>P.10 Provides education and coaching to patients with complex learning needs and atypical responses.</p>	<p>PO.13 Innovative educational programs for patients, families, and groups are developed, implemented, and evaluated.</p>	<p>Opportunities to provide education and coaching using strategies grounded in theory and evidence.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>P.11 Evaluates impact of nursing interventions on patients' aggregate outcomes using a scientific approach.</p>	<p>PO.5 Programs of care are designed for specific populations (e.g., oncology, specific ethnic groups, end-of-life).</p> <p>PO.6 Prevention, alleviation, and/or reduction of symptoms, functional problems, or risk behaviors are achieved.</p> <p>PO.7 Nursing interventions, in combination with interventions by members of other disciplines, result in synergistic patient outcomes.</p> <p>PO.8 Unintended consequences and errors are prevented.</p> <p>PO.9 Predicted and measurable nurse-sensitive patient outcomes are attained through evidence-based practice.</p> <p>PO.10 Interventions have measurable outcomes that are incorporated into guidelines for practice with deletion of inappropriate interventions.</p> <p>PO.12 Desired measurable patient outcomes are achieved. Desired outcomes of care may include improved clinical status, quality of life, functional status, alleviation or remediation of symptoms, patient/family satisfaction, and cost effective care.</p> <p>PO.16 Interventions that are effective in achieving nurse-sensitive outcomes are incorporated into guidelines and policies.</p>	<p>Clinical considerations of measurements (e.g., physiological, behavioral, psychosocial) to evaluate the effect of interventions on patient outcomes. Examples include selecting measurement instruments for evaluation of interventions at the individual, population, and system level, and critiquing the validity, reliability, and clinical applicability of measurement instruments.</p> <p>In relation to aggregate outcomes, theories and evidence related to quality improvement and safety must be considered. Skills related to health informatics and database management and manipulation are also relevant.</p>
<p>P.12 Leads and facilitates coordinated care and transitions in collaboration with the patient and inter-professional team.</p>	<p>PO.5 Programs of care are designed for specific populations (e.g., oncology, specific ethnic groups, end-of-life).</p> <p>PO.11 Collaboration with patients/families, nursing staff, physicians and other healthcare professionals occurs as appropriate.</p> <p>PO.14 Transitions of patients are fully integrated across the continuum of care to decrease fragmentation.</p> <p>NO.6 Desired patient outcomes are achieved through the synergistic effects of collaborative practice.</p>	<p>Development of leadership skills to create a collaborative environment for interprofessional teams. The content encompasses interpersonal qualities (e.g., respectful or relationship-based communication) needed to ensure a healthy work environment and shared goals of the organization. This content area also includes care coordination and transition management.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>P.13 Facilitates patient and family understanding of the risks, benefits, and outcomes of proposed healthcare regimens to promote informed, shared decision-making.</p>	<p>PO.3 Plans of care are appropriate for meeting patient needs with available resources, reflecting patient/family treatment preferences and shared decision-making.</p>	<p>Theoretical foundations for CNS practice includes theories, conceptual models, and research-based evidence that shape the CNS perspective. Content includes theories of health, illness, wellness, learning, stress, palliative care, and shared decision-making.</p> <p>Relationship-based communication, conflict management, crucial conversations, peer feedback, awareness of implicit bias, embracing diversity, and shared decision-making with patients and significant others.</p>
<p>P.14 Facilitates resolution of ethical conflicts in complex patient care situations.</p>	<p>PO.11 Collaboration with patients/families, nursing staff, physicians, and other healthcare professionals occurs as appropriate.</p>	<p>The use of ethical decision-making frameworks as a basis for advocating for patients/families, nurses, other healthcare providers, populations, and the community as a whole. Examples of content include analysis of ethical dilemmas and opportunities to advocate on behalf of others.</p>
CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>P.15 Analyzes the ethical impact of scientific advances, including cost and clinical effectiveness, on patient and family values and preferences.</p>	<p>PO.8 Unintended consequences and errors are prevented.</p>	<p>The use of ethical decision-making frameworks as a basis for advocating for patients/families, nurses, other healthcare providers, populations, and the community as a whole. Examples of content include analysis of ethical dilemmas and opportunities to advocate on behalf of others.</p>
<p>P.16 Advocates for patient's preferences and rights.</p>	<p>PO.3 Plans of care are appropriate for meeting patient needs with available resources, reflecting patient/family treatment preferences and shared decision-making.</p> <p>NO.14 Nurses have an effective voice in decision-making about patient care.</p>	<p>The use of ethical decision-making frameworks as a basis for advocating for patients/families, nurses, other healthcare providers, populations, and the community as a whole. Examples of content include analysis of ethical dilemmas and opportunities to advocate on behalf of others.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
Nurses and Nursing Practice Sphere of Impact		
<p>N.1 Provides expert specialty consultation to nurses related to complex patient care needs.</p>	<p>PO.11 Collaboration with patients/families, nursing staff, physicians, and other healthcare professionals occurs as appropriate.</p> <p>NO.3 The research and scientific base for innovations is articulated, understandable, and accessible.</p> <p>NO.6 Desired patient outcomes are achieved through the synergistic effects of collaborative practice.</p> <p>NO.9 Nurses engage in learning experiences to advance or maintain competence.</p>	<p>Consultation theory and research, and the associated process skills of serving as a clinical expert consultant. Learning activities may include identifying a problem for which a consultant is appropriate, clarifying the role of a consultant in problem-solving, developing alternative strategies for a patient/consultee to consider, understanding revenue-generating processes, and using clinical expertise as a power base.</p> <p>Theoretical and empirical knowledge of illness and wellness phenomena with non-disease and disease-based etiologies.</p>
<p>N.2 Promotes interventions that prevent the impact of implicit bias on relationship building and outcomes.</p>	<p>NO.12 The impact of implicit bias on relationships and outcomes is recognized and minimized.</p>	<p>Development of intellectual skills that underpin the essential characteristics and competencies of the CNS. These skills are used to determine the appropriate application of evidence to individuals or population groups. This content also includes the ability to reframe and hold biases and stereotypes in abeyance.</p> <p>Relationship-based communication, conflict management, crucial conversations, peer feedback, awareness of implicit bias, embracing diversity, and shared decision-making with patients and significant others.</p>
<p>N.3 Advocates for nurses to practice to the full extent of their role in the delivery of healthcare.</p>	<p>NO.5 Nurses are empowered to solve patient care problems at the point of service.</p> <p>NO.14 Nurses have an effective voice in decision-making about patient care.</p>	<p>The use of ethical decision-making frameworks as a basis for advocating for patients/families, nurses, other healthcare providers, populations, and the community as a whole. Examples of content include analysis of ethical dilemmas and opportunities to advocate on behalf of others.</p>
<p>N.4 Leads efforts to resolve ethical conflict and moral distress experienced by nurses and nursing staff.</p>	<p>NO.8 Nurses experience job satisfaction.</p>	<p>The use of ethical decision-making frameworks as a basis for advocating for patients/families, nurses, other healthcare providers, populations, and the community as a whole. Examples of content include analysis of ethical dilemmas and opportunities to advocate on behalf of others.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>N.5 Fosters a healthy work environment by exhibiting positive regard, conveying mutual respect, and acknowledging the contributions of others.</p>	<p>PO.11 Collaboration with patients/families, nursing staff, physicians, and other healthcare professionals occurs as appropriate.</p> <p>NO.8 Nurses experience job satisfaction.</p> <p>NO.11 Competent nursing personnel are retained because of increased job satisfaction and career enhancement.</p>	<p>The focus is on expert interpersonal communication with patients/families, nurses and nursing personnel, and representatives from other disciplines at all levels within the system.</p>
<p>N.6 Employs conflict management and negotiation skills to promote a healthy work environment.</p>	<p>NO.8 Nurses experience job satisfaction.</p> <p>NO.11 Competent nursing personnel are retained because of increased job satisfaction and career enhancement.</p>	<p>Relationship-based communication, conflict management, crucial conversations, peer feedback, awareness of implicit bias, embracing diversity, and shared decision-making with patients and significant others.</p>
<p>N.7 Assesses the nursing practice environment and processes for improvement opportunities.</p>	<p>NO.1 Knowledge and skill development needs of nurses are delineated.</p> <p>NO.11 Competent nursing personnel are retained because of increased job satisfaction and career enhancement.</p>	<p>Quality improvement theories and models, quality improvement processes, process mapping and evaluation, root cause analysis, monitoring of indicators, data analysis and interpretation from a quality improvement perspective, communicating quality information, understanding and measuring a culture of safety, complex adaptive systems and human factors theory and evidence.</p>
<p>N.8 Uses evidence-based knowledge as a foundation for nursing practice to achieve optimal nurse-sensitive outcomes.</p>	<p>PO.6 Prevention, alleviation, and/or reduction of symptoms, functional problems, or risk behaviors are achieved.</p> <p>PO.9 Predicted and measurable nurse-sensitive patient outcomes are attained through evidence-based practice.</p> <p>PO.10 Interventions have measurable outcomes that are incorporated into guidelines for practice with deletion of inappropriate interventions.</p> <p>PO.16 Interventions that are effective in achieving nurse-sensitive outcomes are incorporated into guidelines and policies.</p> <p>NO.2 Evidence-based practices are used by nurses.</p> <p>NO.3 The research and scientific base for innovations is articulated, understandable, and accessible.</p>	<p>Theoretical foundations for CNS practice includes theories, conceptual models, and research-based evidence that shape the CNS perspective. Content includes theories of health, illness, wellness, learning, stress, palliative care, and shared decision-making.</p> <p>Designing and developing nursing assessments, evidence-based interventions, and programs of care. The content includes validating existing practices and identifying the need for innovations. This knowledge area also includes the theoretical and scientific basis for the selection and use of specific nursing assessment instruments and interventions and is the basis for nursing innovation.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>N.9 Mentors nurses and nursing staff in using evidence-based practice principles.</p>	<p>NO.2 Evidence-based practices are used by nurses.</p>	<p>Evidence-based practice processes for the purpose of translating knowledge into nursing practice. Examples of content include identifying problems and examining the evidence base of current practice, creating PICO questions, understanding and leveraging evidence hierarchies, creating effective search strategies, appraising evidence using reliable and valid tools, selecting best practices, using project management skills and knowledge translation theory to apply evidence in practice, evaluating the outcomes of new evidence-based practices, and planning for sustaining gains.</p>
<p>N.10 Leads nurses in the process of planning, implementing, and evaluating change considering intended and unintended consequences.</p>	<p>PO.8 Unintended consequences and errors are prevented.</p> <p>NO.13 Educational programs that advance the practice of nursing are developed, implemented, evaluated, and linked to evidence-based practice and effects on clinical and fiscal outcomes.</p>	<p>Use of theory and evidence to implement change in the practice setting. Examples of experiences and content may include relationship development, empowerment, persuasion, negotiation, and collaboration. Experiences should include project management and knowledge translation. The focus of change strategies includes all three spheres of impact.</p>
<p>N.11 Evaluates the outcomes of nursing practice using methods that provide valid data.</p>	<p>PO.6 Prevention, alleviation, and/or reduction of symptoms, functional problems, or risk behaviors are achieved.</p> <p>PO.8 Unintended consequences and errors are prevented.</p> <p>PO.9 Predicted and measurable nurse-sensitive patient outcomes are attained through evidence-based practice.</p> <p>PO.12 Desired measurable patient outcomes are achieved. Desired outcomes of care may include improved clinical status, quality of life, functional status, alleviation or remediation of symptoms, patient/family satisfaction, and cost effective care.</p> <p>NO.6 Desired patient outcomes are achieved through the synergistic effects of collaborative practice.</p>	<p>Selecting measurement instruments for evaluation of interventions at the individual, population, and system level, and critiquing their validity, reliability, and clinical applicability. Additional content includes consideration of system characteristics, resources, and variance; and methods of selecting outcomes of interest. Other content includes informatics.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>N.12 Facilitates opportunities for nurses, students, and other staff to acquire new knowledge and skills that foster professional development.</p>	<p>NO.1 Knowledge and skill development needs of nurses are delineated.</p> <p>NO.7 Nurses' career enhancement programs are ongoing, accessible, innovative, and effective.</p> <p>NO.9 Nurses engage in learning experiences to advance or maintain competence.</p> <p>NO.11 Competent nursing personnel are retained because of increased job satisfaction and career enhancement.</p>	<p>Theories and evidence about the factors that influence learning, health behaviors, and the teaching and coaching of learners who are patients and their significant others, nurses, and other healthcare professionals. Learning activities may include the process of conducting needs assessments; designing health messages and health education materials to match literacy ability, cultural diversity, and physical capability; using theories and evidence to design teaching strategies to enhance learning; mentoring; and developing professional growth strategies.</p>
<p>N.13 Engages nurses in reflective practice activities that promote self-awareness and invite peer feedback to improve the practice of nursing.</p>	<p>NO.1 Knowledge and skill development needs of nurses are delineated.</p> <p>NO.3 The research and scientific base for innovations is articulated, understandable, and accessible.</p> <p>NO.4 Nurses are able to articulate their unique contributions to patient care and nurse-sensitive outcomes.</p> <p>NO.9 Nurses engage in learning experiences to advance or maintain competence.</p>	<p>Designing strategies related to mentoring and developing professional growth.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>N.14 Mentors nurses to analyze legislative, regulatory, and fiscal policies that impact nursing practice and patient outcomes.</p>	<p>NO.10 Nurses use resources judiciously to reduce overall costs of care and enhance the quality of patient care.</p> <p>NO.13 Educational programs that advance the practice of nursing are developed, implemented, evaluated, and linked to evidence-based practice and effects on clinical and fiscal outcomes.</p> <p>NO.14 Nurses have an effective voice in decision-making about patient care.</p> <p>OO.9 Decision-makers within the institution are informed about practice problems, factors contributing to the problems, and the significance of those problems with respect to outcomes and costs.</p> <p>OO.12 Staff comply with policies, protocols, and standards of care that reflect regulatory requirements and standards.</p> <p>OO.13 Policy-making bodies are influenced to develop regulations/procedures to improve patient care and health services.</p>	<p>CNS participation in advocacy with an emphasis on the CNS role in policy development, influence, and action as well as mentoring nurses in this process.</p>
Organizations/Systems Sphere of Impact		
<p>O.1 Cultivates a practice environment in which mutual respect, communication, and collaboration contribute to safe, quality outcomes.</p>	<p>PO.11 Collaboration with patients/families, nursing staff, physicians, and other healthcare professionals occurs as appropriate.</p> <p>NO.5 Nurses are empowered to solve patient care problems at the point of service.</p> <p>NO.6 Desired patient outcomes are achieved through the synergistic effects of collaborative practice.</p> <p>NO.8 Nurses experience job satisfaction.</p> <p>NO.14 Nurses have an effective voice in decision-making about patient care.</p> <p>OO.11 Patient care programs are aligned with the organization's strategic imperatives, mission, vision, philosophy, and values.</p>	<p>The focus is on expert interpersonal communication with patients/families, nurses and nursing personnel, and representatives from other disciplines at all levels within the system. Examples include relationship-based communication, conflict management, crucial conversations, peer feedback, awareness of implicit bias, embracing diversity, and shared decision-making with patients and significant others. Additional examples include leadership theory, development of leadership skills, team building, and the ability to convey a shared vision for practice.</p> <p>Developing skills to create a collaborative environment for interprofessional teams. The content encompasses interpersonal qualities (e.g., respectful or relationship-based communication) needed to ensure a healthy work environment and shared goals of the organization.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>O.2 Uses leadership, team building, negotiation, collaboration, and conflict resolution skills to build partnerships within and across systems and/or communities.</p>	<p>PO.11 Collaboration with patients/families, nursing staff, physicians, and other healthcare professionals occurs as appropriate.</p> <p>NO.6 Desired patient outcomes are achieved through the synergistic effects of collaborative practice.</p> <p>NO.14 Nurses have an effective voice in decision-making about patient care.</p> <p>OO.4 Policies enhance the practice of nurses individually as members of multidisciplinary teams.</p>	<p>The focus is on expert interpersonal communication with patients/families, nurses and nursing personnel, and representatives from other disciplines at all levels within the system. Examples include relationship-based communication, conflict management, crucial conversations, peer feedback, awareness of implicit bias, embracing diversity, and shared decision-making with patients and significant others. Additional examples include leadership theory, development of leadership skills, team building, and the ability to convey a shared vision for practice.</p> <p>Developing skills to create a collaborative environment for interprofessional teams. The content encompasses interpersonal qualities (e.g., respectful or relationship-based communication) needed to ensure a healthy work environment and shared goals of the organization.</p>
<p>O.3 Consults with health-care 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.</p>	<p>PO.11 Collaboration with patients/families, nursing staff, physicians, and other healthcare professionals occurs as appropriate.</p> <p>OO.5 Innovative models of practice are developed, piloted, evaluated, and incorporated across the continuum of care.</p> <p>OO.8 Stakeholders (nurses, other healthcare professionals, and management) share a common vision of practice outcomes.</p> <p>OO.11 Patient care programs are aligned with the organization's strategic imperatives, mission, vision, philosophy, and values.</p>	<p>Consultation theory and research, and the associated process skills of serving as a clinical expert consultant. The process includes identifying a problem for which a consultant is appropriate, clarifying the role of a consultant in problem-solving, developing alternative strategies for a patient/consultee to consider, understanding revenue-generating processes, and using clinical expertise as a power base.</p> <p>System theory and research to understand, evaluate, and predict individual, group, and organizational behaviors. The content includes skills in participating in change and policy-setting that influence the quality of care within a system.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>O.4 Leads and participates in systematic quality improvement and safety initiatives based on precise problem/etiology identification, gap analysis, and process evaluation.</p>	<p>PO.12 Desired measurable patient outcomes are achieved. Desired outcomes of care may include improved clinical status, quality of life, functional status, alleviation or remediation of symptoms, patient/family satisfaction, and cost effective care.</p> <p>NO.6 Desired patient outcomes are achieved through the synergistic effects of collaborative practice.</p> <p>OO.1 Clinical problems are articulated within the context of the organization/system structure, mission, culture, policies, and resources.</p> <p>OO.11 Patient care programs are aligned with the organization's strategic imperatives, mission, vision, philosophy and values.</p>	<p>Quality improvement theories and models, quality improvement processes, process mapping and evaluation, root cause analysis, monitoring of indicators, data analysis and interpretation from a quality improvement perspective, communicating quality information, understanding and measuring a culture of safety, complex adaptive systems, and human factors theory and evidence.</p>
<p>O.5 Provides leadership for the interprofessional team in identifying, developing, implementing, and evaluating evidence-based practices and research opportunities.</p>	<p>PO.8 Unintended consequences and errors are prevented.</p> <p>OO.1 Clinical problems are articulated within the context of the organization/system structure, mission, culture, policies, and resources.</p> <p>OO.2 Patient care processes reflect continuous improvements that benefit the system.</p> <p>OO.3 Change strategies are integrated throughout the system.</p> <p>OO.5 Innovative models of practice are developed, piloted, evaluated, and incorporated across the continuum of care.</p> <p>OO.9 Decision-makers within the institution are informed about practice problems, factors contributing to the problems, and the significance of those problems with respect to outcomes and costs.</p> <p>OO.12 Staff comply with policies, protocols, and standards of care that reflect regulatory requirements, and standards.</p>	<p>Evidence-based practice processes for the purpose of translating knowledge into nursing practice. Examples of content include identifying problems and examining the evidence base of current practice, creating PICO questions, understanding and leveraging evidence hierarchies, creating effective search strategies, appraising evidence using reliable and valid tools, selecting best practices, using project management skills and knowledge translation theory to apply evidence in practice, evaluating the outcomes of new evidence-based practices, and planning for sustaining gains.</p> <p>Designing and developing nursing assessments, evidence-based interventions, and programs of care. The content includes validating existing practices and identifying the need for innovations. This knowledge area also includes the theoretical and scientific basis for the selection and use of specific nursing assessment instruments and interventions and is the basis for nursing innovation.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>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.</p>	<p>NO.3 The research and scientific base for innovations is articulated, understandable, and accessible.</p>	<p>Designing and developing nursing assessments, evidence-based interventions, and programs of care. The content includes validating existing practices and identifying the need for innovations. This knowledge area also includes the theoretical and scientific basis for the selection and use of specific nursing assessment instruments and interventions and is the basis for nursing innovation.</p>
<p>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.</p>	<p>PO.7 Programs of care are designed for specific populations (e.g., oncology, specific ethnic groups, end-of-life).</p> <p>OO.4 Policies enhance the practice of nurses individually as members of multidisciplinary teams.</p> <p>OO.5 Innovative models of practice are developed, piloted, evaluated, and incorporated across the continuum of care.</p> <p>OO.6 Evidence-based, best practice models are developed and implemented.</p> <p>OO.12 Staff comply with policies, protocols, and standards of care that reflect regulatory requirements and standards.</p>	<p>The evaluation, selection, and use of existing technology, products, and devices that support nursing practice and contribute to improved outcomes. Content may also focus on the development of new technology, products, and devices. Examples of learning activities include evaluating patient education products; using and optimizing informatics; evaluating the sensitivity and specificity of a device to monitor a body function; using strategies to evaluate technology, products, apps, and devices from the perspectives of utility, cost-benefit analysis, ease of use, safety, and effects on patient outcomes; utilizing technology and products to improve patient safety; and evaluating ethical considerations. In addition, content may include consideration of strategies for standardization of products across a system so that errors and variance are reduced.</p>
<p>O.8 Leads and facilitates change in response to organizational and community needs in a dynamic healthcare environment.</p>	<p>PO.8 Unintended consequences and errors are prevented.</p> <p>OO.5 Innovative models of practice are developed, piloted, evaluated, and incorporated across the continuum of care.</p> <p>OO.9 Decision-makers within the institution are informed about practice problems, factors contributing to the problems, and the significance of those problems with respect to outcomes and costs.</p> <p>OO.12 Staff comply with policies, protocols, and standards of care that reflect regulatory requirements and standards.</p>	<p>Use of theory and evidence to implement change in the practice setting. Examples of experiences and content may include relationship development, empowerment, persuasion, negotiation, and collaboration. Experiences should include project management and knowledge translation. The focus of change strategies includes all three spheres of impact.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>O.9 Evaluates system-level interventions, programs, and outcomes based on the analysis of information from relevant sources.</p>	<p>OO.3 Change strategies are integrated throughout the system.</p> <p>OO.5 Innovative models of practice are developed, piloted, evaluated, and incorporated across the continuum of care.</p>	<p>Selecting measurement instruments for evaluation of interventions at the individual, population, and system level, and critiquing their validity, reliability, and clinical applicability. Additional content includes consideration of system characteristics, resources, and variance; and methods of selecting outcomes of interest. Other content includes informatics.</p>
<p>O.10 Demonstrates stewardship of human and fiscal resources in decision-making.</p>	<p>PO.8 Unintended consequences and errors are prevented.</p> <p>PO.10 Interventions have measurable outcomes that are incorporated into guidelines for practice with deletion of inappropriate interventions.</p> <p>OO.2 Patient care processes reflect continuous improvements that benefit the system.</p> <p>OO.5 Innovative models of practice are developed, piloted, evaluated, and incorporated across the continuum of care.</p>	<p>Systems theory and research to understand, evaluate, and predict individual, group, and organizational behaviors. The content includes skills in participating in change and policy-setting that influence the quality and cost of care within a system.</p>
<p>O.11 Disseminates CNS practice and fiscal outcomes to internal stakeholders and the public.</p>	<p>PO.7 Programs of care are designed for specific populations (e.g., oncology, specific ethnic groups, end-of-life).</p> <p>NO.10 Nurses use resources judiciously to reduce overall costs of care and enhance the quality of patient care.</p> <p>OO.10 Patient care initiatives reflect knowledge of cost management and revenue enhancement strategies.</p>	<p>Knowledge of cost-effectiveness evaluation, opportunities to evaluate CNS practice, and participate in the process of disseminating CNS outcomes.</p>

CNS Core Competencies	CNS Outcomes Related to Core Competencies*	Essential Core Content Areas for Developing CNS Competencies
<p>NO.12 Promotes nursing's unique contributions to advancing health to stakeholders (e.g., the organization, community, public, and policy makers).</p>	<p>PO.15 Reports of new clinical phenomena and/or interventions are disseminated through presentations and publications.</p> <p>NO.13 Educational programs that advance the practice of nursing are developed, implemented, evaluated, and linked to evidence-based practice and effects on clinical and fiscal outcomes.</p> <p>OO.7 Nursing care and outcomes are articulated at organizational/system decision-making levels.</p> <p>OO.8 Stakeholders (nurses, other healthcare professionals, and management) share a common vision of practice outcomes.</p> <p>OO.9 Decision-makers within the institution are informed about practice problems, factors contributing to the problems, and the significance of those problems with respect to outcomes and costs.</p>	<p>CNS role in policy development, influence, and action as well as mentoring nurses in this process. Learning activities include opportunities to advocate on behalf of others, participate in forming health policy, interact with policy makers, take action, and promote nursing's contributions toward advancing health.</p>
<p>O.13 Advocates for equitable healthcare by participating in professional organizations and public policy activities.</p>	<p>PO.15 Reports of new clinical phenomena and/or interventions are disseminated through presentations and publications.</p> <p>NO.4 Nurses are able to articulate their unique contributions to patient care and nurse-sensitive outcomes.</p> <p>NO.14 Nurses have an effective voice in decision-making about patient care.</p> <p>OO.4 Policies enhance the practice of nurses individually as members of multidisciplinary teams.</p> <p>OO.7 Nursing care and outcomes are articulated at organizational/system decision-making levels.</p> <p>OO.8 Stakeholders (nurses, other healthcare professionals, and management) share a common vision of practice outcomes.</p>	<p>The use of ethical decision-making frameworks as a basis for advocating for patients/families, nurses, other healthcare providers, populations, and the community as a whole. Examples of content include analysis of ethical dilemmas and opportunities to advocate on behalf of others, health policy formulation, processes of influencing policy makers, and taking action.</p>

<p>O.14 Advocates for ethical principles in protecting the dignity, uniqueness, and safety of all.</p>	<p>OO.13 Policy-making bodies are influenced to develop regulations/procedures to improve patient care and health services.</p>	<p>The use of ethical decision-making frameworks as a basis for advocating for patients/families, nurses, other healthcare providers, populations, and the community as a whole. Examples of content include analysis of ethical dilemmas and opportunities to advocate on behalf of others.</p>
---	--	--

Essential Core Content Areas for Developing Clinical Nurse Specialist Competencies

A content area identifies the subject-matter focus. Content areas do not specify courses because any content area may be represented by integrated threads throughout a CNS curriculum, or may be reflected in a discrete course. Content areas encompass all pertinent learning experiences in the acquisition and application of knowledge to CNS practice. The following areas of content are recommended for inclusion in CNS curricula:

1. Theoretical and empirical foundations for Clinical Nurse Specialist practice.

Description: This content area focuses on theories, conceptual models, empirical knowledge, and research that shape the CNS perspective.

Examples: Theories of health, illness, and wellness; health behavior (including self-care) and health behavior change; and theories of learning, stress, leadership, consultation, collaboration, and organizational development.

Rationale: Theoretical foundations and empirical knowledge are the basis for CNS practice.

2. Phenomena of concern.

Description: This content area focuses on theoretical and empirical knowledge of illness and wellness phenomena with non-disease and disease-based etiologies. Phenomena from all three spheres of impact should be incorporated in the curriculum.

Examples: Symptoms (e.g., nausea, fatigue, pain, dyspnea), cognitive impairment, dementia, iatrogenesis, developmental delay, end-of-life/dying, environmental hazards, impaired mobility, ineffective coping, impaired wound healing, safety, sleep disturbances, unsafe workplace, and workplace violence.

Rationale: Mastery of knowledge of the phenomena of concern to nursing prepares the CNS to differentially diagnose problems that are amenable to existing or innovative interventions, particularly in patients with complex and multifactorial health conditions. This knowledge also enables the CNS to articulate nursing's unique contributions to patient care, collaborate with other healthcare professionals, and identify outcomes of care reflective of CNS interventions.

3. Design and development of evidence-based innovative nursing interventions.

Description: This content area focuses on the design and development of nursing assessments, evidence-based interventions, and programs of care. The content includes validating existing practices and identifying the need for innovations. This knowledge area also includes the theoretical and scientific basis for the selection

and use of specific nursing assessment instruments and interventions, and is the basis for nursing innovation. Innovations are focused on cost-effectiveness and quality patient care.

Examples: Implementing innovative evidence-based, cost-effective interventions to decrease medication errors; designing a program for parents of dying children; creating an innovative community-based screening and education program for patients at high risk for chronic obstructive lung disease; and applying innovative interventions to decrease risk.

Rationale: This content is critical for CNSs because it requires graduate-level analysis and synthesis of theory and evidence. Clinical nurse specialists develop innovative assessments and interventions with cost-effective outcomes, thus advancing the practice of nursing.

4. Clinical inquiry/critical thinking using advanced knowledge.

Description: This content area focuses on the development of intellectual skills that underpin the essential characteristics and competencies of the CNS. Those cognitive skills are applied by questioning current practice in order to advance practice for nursing, recognizing the nuances of patient experiences, and identifying the commonalities and uniqueness among population groups. Those skills are used to determine the appropriate application of evidence to individuals or population groups. This content also includes the ability to reframe and hold biases and stereotypes in abeyance.

Examples: Critical thinking, diagnostic reasoning, pattern identification, clinical decision making, and problem-solving strategies.

Rationale: Clinical nurse specialist practice requires the ability to understand and synthesize multiple perspectives, be aware of personal thinking patterns, and make effective decisions that enhance nursing practice and improve quality and cost-effectiveness.

5. Healthcare technology, products, and devices.

Description: This content area focuses on the evaluation, selection, and use of existing technology, products, and devices that support nursing practice and contribute to improved outcomes. Content may also focus on the development of new technology, products, and devices.

Examples: Evaluating patient education products; using and optimizing informatics; evaluating the sensitivity and specificity of a device to monitor a body function; using strategies to evaluate technology, products, apps, and devices from the perspectives of utility; cost-benefit analysis, ease of use, safety, and effects on patient outcomes; using technology and products to improve patient safety; and evaluating ethical considerations. In addition, content includes consideration of strategies for standardization of products across a system so errors and variance are reduced.

Rationale: Clinical nurse specialists are experts on technology, products, and devices in their respective specialty areas. Clinical nurse specialists are coaches to patients, family members, nursing personnel, and consultants to purchasing

departments and technology development companies. In an increasingly complex healthcare system, technology, products, and devices play a large role in supporting nursing practice.

6. Teaching and coaching.

Description: This content area focuses on theories and evidence about the factors that influence learning, health behaviors, and the teaching and coaching of learners including patients, families, nurses, and other healthcare professionals.

Examples: Conducting needs assessments; designing health messages and health education materials to match literacy ability, cultural diversity, and physical capability; using theories and evidence to design teaching strategies to enhance learning; mentoring; and developing professional growth strategies.

Rationale: The CNS is responsible for developing innovative educational programs for patients, families, nurses, and other healthcare personnel. A continuing focus of CNS practice is teaching and coaching, particularly in the patient/client and nursing personnel spheres of impact. Approaches must be theory and evidence-based, accessible, learner-friendly, cost-effective, and patient-centered. They must lead to meaningful outcomes.

7. Influencing change.

Description: This content area focuses on theory and evidence-based approaches to implementing change in the practice setting.

Examples: Using theory and evidence to develop and use strategies to create change in the practice setting. Change strategies may involve developing relationships, empowerment, persuasion, negotiation, and collaboration. Experiences should include project management and knowledge translation. The focus of change strategies includes all three spheres of impact.

Rationale: Changes in healthcare delivery require more egalitarian and empowering relationships with patients; require nurses to change how they interact with patients and others; and necessitate that systems expand their services to include health promotion, prevention, and interprofessional practice groups to achieve desired outcomes and consumer satisfaction. Those shifts require increased use of collaborative and mutually derived approaches that depend on influence, persuasion, and negotiation between CNSs and patients, nurses, and other providers. Knowing how to influence organizational change through skillful negotiation is an essential part of CNS practice.

8. Systems thinking.

Description: This content area focuses on system theory and research to understand, evaluate, and predict individual, group, and organizational behaviors. The content includes skills in participating in change and policy setting that influence the quality and cost of care in a system.

Examples: Assessing organizational culture, including formal and informal power bases; understanding how a change in one unit may create unintended adverse outcomes in another unit; engaging informal leaders in a planned change strategy; being able to constructively use system-level feedback to influence policies and

standards of care; creating and evaluating organizational policy; and helping organizations respond proactively to outside influences requiring regulatory or other change. In addition, theories and evidence related to healthy work environments, organizational behavior, and change related to organizational learning and development should be included.

Rationale: Healthcare is delivered in a complex system. Clinical nurse specialists need to understand the context in which nursing care is delivered, and develop strategies for influencing change and creating innovation.

9. Leadership for interprofessional collaboration.

Description: This content area focuses on developing leadership skills to create a collaborative environment for interprofessional teams. The content encompasses interpersonal qualities (e.g., respectful or relationship-based communication) needed to ensure a healthy work environment and shared goals of the organization. This content area also includes care coordination and transition management.

Examples: Developing facilitators and removing barriers to collaboration, working within the organizational culture, articulating nursing's unique contributions in the context of interprofessional teams, describing shared risks and benefits of collaboration, communicating with respect, engaging in risk-taking behaviors, and promoting the organization's vision.

Rationale: Successful nursing-care delivery depends on the quality of interprofessional collaboration and is essential to improve the quality of care and ensure that care is safe and patient-centered (IPEC, 2016).

10. Consultation theory.

Description: This content area focuses on consultation theory and research, and the associated process skills of being a clinical expert consultant.

Examples: Identifying a problem for which a consultant is appropriate, clarifying the role of a consultant in problem solving, developing alternative strategies for a patient/consultee to consider, understanding revenue-generating processes, and using clinical expertise as a power base.

Rationale: Consultation skills are essential when working with patients, nurses, or other healthcare providers. Consultation activities promote collaboration with other healthcare professionals, and lead to resolving complex patient problems, developing best practice models, and improving systems of care.

11. Quality improvement and safety.

Description: This content area focuses on theories and evidence related to quality improvement and safety. Understanding the science of quality improvement and patient safety is essential for CNSs to be effective in the practice setting.

Examples: Quality improvement theories and models, quality improvement processes, process mapping and evaluation, root cause analysis, monitoring of indicators, data analysis and interpretation from a quality improvement perspective, communicating quality information, understanding and measuring a culture of safety as well as knowledge of a safety culture, complex adaptive systems, and human factors theory and evidence.

Rationale: A hallmark of CNS practice is ensuring patient safety and quality. To be effective, practicing CNSs must understand quality improvement models and processes.

12. Measurement and outcome evaluation methods.

Description: This content area focuses on clinical considerations of measurements (e.g., physiological, behavioral, psychosocial) required to assess and diagnose problems, and research methods and techniques to evaluate nurse-sensitive outcomes consistent with the organization's mission and goals. Those methods are also important in the development of databases relevant to evaluation of CNS practice outcomes, and efficacy of treatment at the patient and population level. Evaluation methods include various units of analysis in the system, the generation of cost-effectiveness/cost-benefit data, and monitoring of outcome indicators over time.

Examples: Selecting measurement instruments for evaluation of interventions at the individual, population, and system level; and critiquing their validity, reliability, and clinical applicability. Additional content includes consideration of system characteristics, resources, and variance; methods of selecting outcomes of interest; dissemination of nurse-sensitive and CNS outcomes both within and external to the organization; and communicating the fiscal implication of the outcomes measured.

Rationale: Clinical nurse specialists use instruments to measure phenomena of concern to nursing and monitor indicators of quality pertinent to making system-level changes. Clinical nurse specialist decision-making must be based on data and compared with benchmarks to achieve optimal outcomes. Understanding measurement is critical to CNS leadership in assuring quality, cost-effective outcomes. Clinical nurse specialists must also provide evidence of dependable, cost-effective, and high-quality care as outlined by NACNS (2013). Clinical nurse specialists must continue to use evaluation strategies to demonstrate cost-effectiveness of programs. Program and outcome evaluation are necessary to enhance organizational performance.

13. Evidence-based practice and knowledge translation.

Description: This content area focuses on the evidence-based practice process for translating knowledge into nursing practice.

Examples: Identifying problems and examining the evidence base of current practice; creating Problem/Patient/Population, Intervention, Comparison or Control, Outcome (PICO) questions (see Appendix A); understanding and leveraging evidence hierarchies; creating effective search strategies; appraising evidence using reliable and valid tools; determining best practices; using project management skills and knowledge translation theory to apply evidence in practice; evaluating the outcomes of new evidence-based practices; planning for sustaining gains; and disseminating the outcomes of evidence implementation.

Rationale: Evidence-based practice and knowledge translation are important competencies for CNSs. The ability to conduct an analysis and synthesis of evidence is necessary to develop practice guidelines that will improve quality outcomes (IOM, 2001).

14. Interpersonal communication and leadership.

Description: This content area focuses on expert interpersonal communication with patients/families, nurses and nursing personnel, and representatives from other disciplines at all levels within the system.

Examples: Relationship-based communication, conflict management, crucial conversations, peer feedback, awareness of implicit bias, embracing diversity, and shared decision-making with patients and significant others. Additional examples include leadership theory, development of leadership skills, team building, and the ability to convey a shared vision for practice.

Rationale: The ability to effectively communicate is essential for CNS practice. Clinical nurse specialists must learn how to build trust and use that trust to improve practice. The process of building trust relies on effective interpersonal communication and leadership skills.

15. Advocacy and ethical decision-making.

Description: This content area focuses on the use of ethical decision-making frameworks as a basis to advocate for patients/families, nurses, other healthcare providers, populations, and the community. This area also focuses on the CNS role in policy development, influence, and action; and mentoring nurses in this process. As advocates, CNSs have a responsibility to promote nursing's unique contributions to advancing health to key stakeholders.

Examples: Ethical frameworks, analysis of ethical dilemmas, opportunities to advocate on behalf of others, health policy formulation, processes of influencing policymakers, taking action, and promoting nursing's contributions to advancing health.

Rationale: Clinical nurse specialists are voices for their patients and families, and advocate for them to ensure quality care. They also advocate on behalf of nurses and are liaisons between nurses at the unit level and upper administration, providing a voice for nursing concerns. Finally, CNSs bring their voice to the policy arena, advocating for nurses and patient/nursing issues.

Additional Educational Preparation

In addition to the core content areas, the practice and socialization experiences of CNS students are shaped by the following:

1. Opportunities for students to develop competencies in the three spheres of impact through preceptorships with Clinical Nurse Specialists.

Preceptorships provide continuing experiences with peer review and establish a network of CNS colleagues who can be resources for continuing development and professional collaboration. Clinical nurse specialist students may augment clinical experiences by working with other healthcare providers appropriate to the specialty. However, the emphasis of CNS student clinical experiences must be on learning the CNS role and practice competencies under the guidance of an experienced CNS preceptor.

2. Opportunities to individualize the program of study to meet personal career goals and competencies related to the Clinical Nurse Specialist's specialty.

Educational programs need to provide content on both CNS core competencies and give students opportunities to pursue specialty competencies if the education program purports to prepare students for practice in a specialty area. Faculty in many schools preparing CNSs report use of the NACNS *Statement* as required reading for their students to assist in learning about CNS core competencies. Other documents will be needed to supplement this and provide information about specialty competencies.

3. Socialization experiences for full and part-time students as a continuing process from the time of matriculation to graduation.

Clinical nurse specialist educational preparation is more than the sum of completed courses. To become a clinical and professional leader, a CNS must integrate acquired knowledge and competencies with activities that enable the CNS to build a network with other CNSs and nursing and policy leaders.

SUMMARY

Recommendations for graduate education of the CNS address core competencies and outcomes of CNS practice in the three spheres of impact. The recommendations for curricula focus on essential content areas and threads, using some of the recommendations of the AACN with NACNS-recommended additions, to produce specific competencies of the CNS. For preparation in a specialty area, schools of nursing may provide additional courses and experiences beyond these recommendations.

In addition to the core content, CNS students should have opportunities to individualize their programs of study to meet personal career goals and develop specialty area competencies. Students should be precepted by CNSs who exemplify competencies and can facilitate students' socialization into their roles.

It is recognized that some schools of nursing and their CNS programs and curricula do not address the recommendations of this document. It is recommended that faculty teaching in or planning to teach in a CNS program use this *Statement* to develop new programs or to revise curricula.

CHAPTER 6

Criteria for the Evaluation of Clinical Nurse Specialist Master's, Practice Doctorate, and Postgraduate Certificate Educational Programs

INTRODUCTION

The original document outlining criteria for evaluating CNS master's, practice doctorate, and postgraduate certificate educational programs was created by a national task force in 2009-2010. The document was validated in 2010-2011 by a large panel representing diverse professional nursing organizations. The final document was published in 2011 by NACNS (Validation Panel of the National Association of Clinical Nurse Specialists, 2011). The development and validation processes used at that time are published in the 2011 document. The criteria contained in this statement have been updated to reflect current competencies and practice.

Recommendations for using the criteria indicated they were to be used to evaluate CNS master's, practice doctorate, and postgraduate certificate educational programs and to serve as an adjunct to existing national accreditation standards. In addition, the standards could be used to guide development of new CNS programs and conduct self-evaluation of new and existing CNS programs. This stated purpose of the criteria has not changed, and the criteria can continue to be used as stated above.

This section of the statement includes two main components: 1) criteria for the evaluation of CNS master's, practice doctorate, and postgraduate certificate programs; and 2) required and recommended documentation for evaluating CNS education programs.

Evaluation Criteria

The criteria for evaluating CNS master's and practice doctorate educational programs follow. These are organized into five (5) sections—Program Organization and Administration; Program Resources including faculty, clinical, and institutional; Student Admission, Progression, and Graduation Requirements; Curriculum; and Program Evaluation. Each criterion is explained in greater depth in an elaboration section, and the required/recommended documentation for each criterion is specified.

CRITERION 1.

Clinical Nurse Specialist Program Organization and Administration

1-1. The Clinical Nurse Specialist program operates within, or is affiliated with, an institution of higher education. The program is accredited by a nursing accrediting body recognized by the U.S. Department of Education.

Elaboration:

The CNS program must exist within an academic nursing unit that operates within or is affiliated with an institution of higher education. The program must be at the graduate level and accredited by a nationally-recognized nursing accrediting body (e.g., Accreditation Commission for Education in Nursing [ACEN], Commission

on Collegiate Nursing Education [CCNE], and Commission for Nursing Education Accreditation [CNEA]).

Documentation (Required):

- Description of program’s relationship with the institution of higher education.
- Evidence that the program is at the graduate level.
- Evidence of current accreditation from a nationally-recognized nursing accrediting body.

1-2. The purpose of the Clinical Nurse Specialist program is clear, and the program outcomes are clearly aligned with the mission of the parent institution and the mission/goals of the nursing unit.

Elaboration:

The purpose of the CNS program must clearly define the population focus area and any additional specialty preparations. The program outcomes/competencies should reflect preparation at the graduate level and be congruent with the mission of the parent institution and the nursing unit.

Throughout these criteria, “population” and “specialty” are used in accord with the definitions outlined in the APRN Consensus Work Group (2008) document.

Documentation (Required):

- Evidence of congruence among the purpose of the CNS program, the mission of the parent institution, and the mission/goals of the nursing unit.
- Evidence of congruence among the program outcomes/competencies, mission of the parent institution, and mission/goals of the nursing unit.

1-3. The individual who has responsibility for the overall leadership or oversight of the Clinical Nurse Specialist program:

- Has educational and/or experiential preparation for the CNS role.
- Holds a master’s or doctoral degree in nursing.
- Documents experience in graduate education.
- Is recognized/licensed by the Board of Nursing of the state(s) in which the program is based.
- Has responsibility for ensuring that the program adheres to national CNS educational standards.

Elaboration:

There must be a full-time faculty member designated to provide overall leadership or oversight of the CNS program. That individual must have educational and/or experiential preparation for the CNS role in a population focus area congruent with a focus of the program. Lead faculty must also meet state/territorial regulatory requirements regarding education preparation, licensure, and certification. Based on the type of accreditation held by the nursing program, it may be necessary that lead CNS faculty have national certification in role and population even if it is not required by state/territorial regulations. The faculty member designated

to lead the CNS program is expected to keep abreast of current standards and trends in CNS education and practice, and ensure adherence to national CNS standards. Although not required, it is strongly recommended that the individual who has responsibility for the overall leadership or oversight of the CNS program be prepared at the doctoral level.

Documentation (Required):

- Description of the duties and responsibilities of the faculty member designated to lead the CNS program.
- Evidence of how the faculty member designated to lead the CNS program advances the purpose, mission, goals, and outcomes of the program.
- Curriculum vitae of the faculty member designated to lead the CNS program, which documents educational preparation and/or national certification as a CNS in a population focus area congruent with one of the foci of the program.
- Current credential as an APRN in the state/territory in which the program exists.

Documentation (Recommended):

- List of publications and other scholarly activities relevant to CNS practice/education and membership/leadership in professional organization(s) that focus on advancing or documenting the impact of CNS practice/education.
- Throughout these criteria, “doctorate” refers to a practice or research doctorate.

CRITERION 2.

Clinical Nurse Specialist Program Resources: Faculty, Clinical, and Institutional—FACULTY

2-1a. Faculty who teach in the Clinical Nurse Specialist program have appropriate credentials, education, and experience that prepares them for such teaching responsibilities.

2-1b. Faculty who teach Clinical Nurse Specialist role and clinical practice courses have master’s, postgraduate, or practice doctorate preparation as a Clinical Nurse Specialist.

Elaboration:

Faculty teaching CNS role or clinical practice courses in the CNS program must hold the academic credentials, qualifications, and experience needed for such teaching responsibilities. It is strongly recommended that faculty teaching in the practice doctorate CNS program hold earned practice or research doctorates or have a clearly outlined plan for attaining such preparation.

Documentation (Required):

- Profile table of all faculty teaching in the CNS program documenting everyone’s credentials, education, certification(s), experience, and courses taught for the past two years.
- Curriculum vitae of all faculty members teaching in the CNS program.

- Plan to attain doctoral preparation for each master's-prepared faculty member teaching in the practice doctorate CNS program who does not currently hold that degree.

2-2. Faculty who teach in the Clinical Nurse Specialist program maintain expertise in their areas of specialization and contribute to the field by engaging in scholarly projects and professional leadership activities that promote evidence-based practice and improve health outcomes, or through other activities in one or more of the three spheres of impact (patient direct care, nurses/nursing practice, organizations/systems).

Elaboration:

Faculty members teaching in the CNS program demonstrate expertise in at least one of the three spheres of impact through some form of faculty practice, which may include clinical care, scholarly projects (including evidence-based practice), consultation, or research with clinical implications.

Documentation (Required):

- Evidence of the practice or contributions made by each faculty member teaching in the CNS program as they relate to one or more of the spheres of impact.
- Examples of the leadership activities of faculty members teaching in the CNS program, including national/state/regional service in professional associations.
- Evidence of the professional development activities of faculty members teaching in the CNS program that help maintain expertise in the area of specialization and the area(s) of teaching responsibility.
- Examples of the scholarly activities of faculty members teaching in the CNS program such as publications, grants, presentations, evidence-based practice contributions, and so forth.

2-3. Faculty who teach in the Clinical Nurse Specialist program must be sufficient in number and expertise to teach all courses, support the professional role development of students, implement essential clinical learning experiences, develop policies, advise students, and engage in ongoing curriculum development and evaluation.

Elaboration:

It is essential to have an adequate cadre of full-time and part-time faculty teaching in the CNS program to provide quality learning experiences for students, engage in ongoing curriculum review and refinement, mentor students and junior faculty, guide preceptors, and provide continuity regarding implementation of the program.

Documentation (Required):

- Copies of teaching assignments for all faculty teaching in the CNS program for the past two years.
- Plan to develop and/or maintain a cadre of qualified full-time faculty to teach and maintain the quality and stability of the program.

CRITERION 2.**Clinical Nurse Specialist Program Resources: Faculty, Clinical, and Institutional—CLINICAL**

2-4. Sufficient number of faculty and clinical preceptors are available to ensure quality clinical experiences for Clinical Nurse Specialist students and provide adequate direct and indirect supervision and evaluation of students enrolled in clinical practice courses. Faculty/student ratios must conform to any state boards of nursing requirements.

Elaboration:

Adequate and appropriately credentialed faculty and clinical preceptors to teach the clinical components of the CNS program are essential for effective program implementation. The recommended ratio for direct supervision (by the faculty member or clinical preceptor) is 1:1 or 1:2. The recommended ratio for indirect supervision (by the faculty member) is 1:6 to 1:8. Such ratios ensure quality clinical learning experiences for students, and effective evaluation of student performance.

Documentation (Required):

- List of all full-time and part-time faculty, including credentials, involved in teaching clinical CNS courses during the past two years, indicating whether each provided direct or indirect supervision.
- List of faculty-student and preceptor-student ratios for all CNS clinical courses taught during the past two years, indicating whether each was direct or indirect supervision.
- Description of mechanisms for determining faculty-student and preceptor-student ratios and evaluating whether they provide quality outcomes.
- Explanation of any variations in the recommended faculty-student or preceptor-student ratios noted in the elaboration section.
- Documentation of state Board of Nursing requirements (when available) regarding faculty-student and/or preceptor-student ratios, and how the CNS program meets those requirements.

2-5. When preceptors are involved in the clinical supervision of students, the faculty who teach in the Clinical Nurse Specialist program retain ultimate responsibility for evaluating student performance and the quality of the clinical experiences.

Elaboration:

When preceptors are used by the CNS program, they are expected to provide evaluative feedback to students and faculty regarding students' clinical performance. The criteria for those evaluations are to be provided by faculty members teaching in the program, and they have ultimate responsibility for evaluating student performance and evaluating the quality of students' clinical experiences.

Documentation (Required):

- Criteria for selection/appointment of clinical preceptors.
- Methods of communication between faculty and clinical preceptors regarding student performance and the adequacy of the clinical experience.
- Evaluation criteria used to assess student performance in each CNS clinical course.

2-6. Preceptors, who are authorized to practice in the Clinical Nurse Specialist role through educational preparation and/or Clinical Nurse Specialist certification, supervise students in clinical practice experiences through direct or virtual interactions. Other professionals also may be preceptors for clinical experiences.

Elaboration:

Clinical preceptors must be educationally and experientially-prepared to mentor students in the CNS role. If CNS preceptors are not available or additional professional expertise is deemed essential for the student's education, other professionals (for example, master's- or doctorally-prepared nurse practitioners, physicians, nutritionists, social workers, psychologists, nurses, or other health professionals with advanced preparation and specialized expertise) may precept CNS students for circumscribed experiences.

Documentation (Required):

- Evidence that student clinical practice experiences are supervised by CNS preceptors or CNS faculty members.
- Copies of agreements/contracts with all preceptors involved in the CNS program during the past two years.
- Evidence that all preceptors hold the appropriate professional degrees and credentials.
- Documentation of verification of all preceptors' credentials, educational or experiential preparation, and unencumbered professional licenses.
- Description of a plan to increase the number of educationally and experientially-prepared preceptors is provided when CNS preceptors are not available for essential supervision of students.

2-7. Preceptors who supervise Clinical Nurse Specialist students in clinical settings are oriented to curriculum requirements, practice course objectives, and expectations regarding student supervision and evaluation.

Elaboration:

Preceptors are better able to supervise CNS students when they receive enough information about the specific courses in which the students are enrolled and how the experience they share with students relates to the overall program outcomes/competencies. The preceptor's role in supervision and evaluation should be evident to all concerned—preceptor, student, and faculty.

Documentation (Required):

- Description of how preceptors are oriented to the CNS program outcomes/competencies, specific course objectives, and their responsibilities related to the supervision and evaluation of students.
- Copies of orientation documents provided to preceptors.

2-8. Clinical facilities are sufficient in quality and number to provide experiences that give Clinical Nurse Specialist students ample opportunities for role development, implementation of nationally-validated Clinical Nurse Specialist competencies in the three spheres of impact (patient direct care, nurses/nursing practice, organizations/systems), and meeting Clinical Nurse Specialist/Advanced Practice Registered Nurse certification/licensure requirements.

Elaboration:

Sufficient clinical facilities are essential to support student practice experiences in all three spheres of impact to enhance role development and prepare students to meet certification/licensure requirements in the role and population focus. Student experiences in all three spheres of impact help them develop skills in all of the nationally validated CNS competencies and expand their career opportunities.

Documentation (Required):

- Description of clinical facilities available and used for student practice experiences in the past two years.
- Examples of the experiences available in clinical facilities regarding each sphere of impact.
- Examples of student practice experiences related to each sphere of impact.
- Examples of current agreements/contracts with facilities used for CNS clinical practice experiences (all agreements/contracts must be on file).

CRITERION 2.

Clinical Nurse Specialist Program Resources: Faculty, Clinical, and Institutional—INSTITUTIONAL

2-9. Resources are sufficient to support the ongoing professional development, scholarly activities, and practice of faculty who teach in the Clinical Nurse Specialist program.

Elaboration:

Faculty members are expected to engage in professional development and scholarly activities, and continue their practice to remain current. Such activities must be supported, at least in part, by the program.

Documentation (Required):

- Description of the support provided to faculty who teach in the CNS program that allows them to enhance their professional development, engage in scholarly activities, and engage in practice.

2-10a. Learning resources and support services for on-campus/face-to-face and online/distance environments are sufficient to ensure educational quality in the Clinical Nurse Specialist program.

2-10b. Institutional resources, facilities, and services needed to support the development, implementation, and evaluation of the Clinical Nurse Specialist program are available to faculty and students.

Elaboration:

Technology, library, faculty development, support systems, and other resources are essential to support faculty in designing and implementing teaching and evaluation methods in all courses in the CNS program, and to ensure a quality educational experience. The institution therefore must provide resources, facilities, and services sufficient in number and quality to support faculty and students in all aspects of the CNS program.

Documentation (Required):

- Description of resources and support systems in place to support faculty in designing and implementing effective teaching and evaluation methods.
- Description of how the institution supports faculty and students in the CNS program with resources, facilities, and support services (including technology support for distance education) to ensure program quality and student success.

CRITERION 3.

Student Admission, Progression, and Graduation Requirements

3-1. The Clinical Nurse Specialist program builds on baccalaureate level nursing competencies and culminates in a master's degree, postgraduate certificate, or doctorate.

Elaboration:

Since CNSs are APRNs, their education must be at the graduate level and build upon baccalaureate nursing competencies. In light of the many paths for the educational preparation of nurses, graduate preparation for the CNS role may be at the master's level, through a postgraduate certificate program, or through a practice doctorate program.

Documentation (Required):

- Evidence that the CNS program meets appropriate expectations outlined by national organizations for graduate and APRN programs.
- Documentation that the CNS program builds on baccalaureate nursing competencies and, as appropriate to the degree being awarded, on nationally-recognized graduate level nursing competencies.

3-2. Faculty who teach in the Clinical Nurse Specialist program participate in developing, approving, and revising the admission, progression, and graduation criteria for the program.**Elaboration:**

The role of faculty teaching in the CNS program in developing and implementing admission, progression, and graduation criteria related to that program must be clear. Such faculty must have the authority and responsibility to make decisions regarding student admissions and progression through the program.

Documentation (Required):

- Description of the admission and progression criteria for students in the CNS program.
- Evidence of how faculty teaching in the CNS program are involved in making decisions about admissions to that program.
- Evidence of how faculty teaching in the CNS program are involved in establishing progression guidelines and making decisions related to student progression through that program.
- Aggregate data about qualifications of students admitted to the CNS program, their progression through it, graduation rates, graduates' success on national certification exams (if available), and state licensure/recognition as a CNS/APRN.

3-3. All students in the Clinical Nurse Specialist program must hold unencumbered licensure as a registered nurse before and throughout their enrollment in Clinical Nurse Specialist clinical courses.**Elaboration:**

Since the CNS program prepares students for an advanced practice role in nursing and requires their involvement in patient care during clinical courses, students must meet legal requirements to practice as a RN.

Documentation:

- Description of how the current RN license of all students in the CNS program is verified.
- Documentation that files are maintained showing evidence of licensure validation.

CRITERION 4.**Clinical Nurse Specialist Curriculum****4-1. The curriculum is congruent with state requirements, national standards for graduate APRN programs, and nationally-recognized master's level or DNP Clinical Nurse Specialist competencies.****Elaboration:**

The CNS curriculum should incorporate appropriate theory and clinical courses consistent with state requirements and nationally endorsed standards, guidelines, and competencies for graduate, APRN, and CNS programs. Graduates of the program should be prepared to practice in the CNS role and pass a national certification exam appropriate to the population-focused area. Preparation for meeting graduate-level CNS competencies and effectiveness within the three CNS spheres of impact should be reflected in the curriculum. Postgraduate certificate program graduates are expected to meet the same CNS competencies as master's or practice doctorate program graduates.

Documentation (Required):

- Copy of the program of study showing core, role, population and, if appropriate, specialty courses for each track or where core, role, and population competencies are integrated.
- Syllabus for each course in the CNS program, including course descriptions, objectives, credits, didactic/clinical allocations, and relationship to nationally-recognized graduate core, APRN core, CNS role/population-focused core standards, and the three spheres of impact.
- Description of how the program uses state requirements, nationally-endorsed standards and guidelines, and each of the following to develop and refine the curriculum:
 - Nationally-endorsed CNS master's and/or practice doctorate competencies.
 - *AACN Master's Essentials* (2011) and/or *DNP Essentials* (2006).
 - *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education* (2008).
- Evidence that the curriculum prepares students to meet the criteria for eligibility to take the appropriate national certification examination (when available) and for state licensure/recognition as a CNS/APRN.

4-2. The Clinical Nurse Specialist program requires a minimum of 500 supervised clinical (clock) hours for master's and postgraduate preparation. A minimum of 1,000 supervised clinical (clock) hours are required for post-baccalaureate practice doctorate preparation.**Elaboration:**

Clinical Nurse Specialist students must have an opportunity to practice the CNS role in settings related to the population/focus area and, if appropriate, the specialty of the program under the supervision of a CNS faculty member and/

or a qualified CNS preceptor. “Clinical (clock) hours” refers to hours in which the student implements the CNS role in one or more of the three spheres of impact. (Skills lab hours and physical assessment practice sessions are not included in the calculation of clinical [clock] hours).

Combined CNS/NP programs must include clinical experiences in both the CNS and NP roles and population/focus area, and must prepare students to be eligible for certification as a CNS. A minimum of 500 clinical (clock) hours must be spent in postgraduate programs preparing for the CNS role and population/focus area of practice. A minimum of 1,000 clinical (clock) hours must be spent in post-baccalaureate programs preparing nurses for the CNS role at the practice doctorate level.

Clinical nurse specialist programs preparing graduates for practice in a specialty area of practice in addition to the population/focus area must document how clinical experiences address both. It is expected that the number of required clinical hours will be higher for a program that prepares students for CNS practice in a specialty area in addition to the population/focus area.

Documentation (Required):

- Evidence that validates a minimum of 500 clinical (clock) hours in the master’s and postgraduate certificate CNS program.
- Evidence that validates a minimum of 1,000 clinical (clock) hours in the post-baccalaureate practice doctorate program.

CRITERION 5.

Clinical Nurse Specialist Program Evaluation

5-1. There is a comprehensive evaluation plan for the Clinical Nurse Specialist program that addresses the curriculum, faculty resources, student outcomes, clinical sites, preceptors, and program resources.

Elaboration:

A comprehensive plan for evaluating the CNS program that specifies the what, who, when, and how of data collection is essential to ensure continued program quality. The plan must provide for regular reviews (for example, every five years or more frequently as certification or national standards are updated/revised), document how results of the evaluation are used for program improvement, and describe how faculty determine that program outcomes/competencies are met.

Documentation (Required):

- Copy of the comprehensive evaluation plan that describes systematic evaluation of the didactic and clinical experiences, preceptors, clinical sites, and faculty involved in the CNS program.
- Evidence that the evaluation of the CNS program is integral to the nursing unit’s overall evaluation plan.
- Documentation of how evaluation results have been used for program improvement.

- Timeline for the ongoing, systematic evaluation of the CNS curriculum.
- Documentation of regular, formal reviews of the CNS curriculum by faculty teaching in that program.

5-2. The Clinical Nurse Specialist program collects and aggregates data from a variety of sources to evaluate achievement of program outcomes.

Elaboration:

The CNS program must develop and implement a plan to evaluate the extent to which program outcomes/competencies have been achieved, incorporating the perspective of students, alumni, graduates' employers, clinical partners/preceptors, and other significant stakeholders. Aggregate data from program evaluations should be reviewed regularly by faculty teaching in the CNS program and used for ongoing improvement of the program.

Documentation (Required):

- Instruments/methods/measures used to collect data needed for a comprehensive program evaluation. Such measures may include: graduate/alumni satisfaction, employment after program completion, employer satisfaction, certification pass rates, and program retention and graduation rates, among others.
- Aggregate data (such as average time to complete the program, graduation rates, pass rates on national certification exam, and state licensure/approval as a CNS/APRN) from students, alumni, graduates' employers, and other stakeholders for the past two years.
- Reports of analyses of data that document CNS program strengths, areas needing improvement or refinement, and strategies designed to address areas of concern.
- Examples of program changes made based on findings from the program evaluation.

Documentation (Recommended):

- Minutes of curriculum meetings where program outcome data were analyzed and recommendations for program improvement were formulated.

5-3. Faculty who teach and students who are enrolled in the Clinical Nurse Specialist program have input in the ongoing development, evaluation, and revision of the program.

Elaboration:

Faculty who teach in the CNS program are knowledgeable about national practice standards, guidelines for graduate nursing education, and guidelines for CNS education. They also understand the curriculum structure and content, and the learning experiences necessary to adequately prepare CNSs for their evolving role. Students also have a vested interest in the program since they are

the ones who experience it and who desire to be exceptionally well-prepared to assume the CNS role upon graduation. Therefore, both students and faculty should participate in designing, evaluating, and revising the CNS program.

Documentation (Required):

- Description of processes in place that provide for faculty and student input in the development, evaluation, and refinement of the CNS curriculum.
- Examples of how students and faculty have been engaged in curriculum development, evaluation, and refinement.

Documentation (Recommended):

- Minutes from CNS faculty and/or graduate program meetings that illustrate curriculum development and decision-making by faculty.
- Minutes from CNS faculty meetings that illustrate how student input is incorporated in decisions related to curriculum design and implementation.

5-4. The Clinical Nurse Specialist curriculum is evaluated on an ongoing basis, using relevant data to inform revisions.

Elaboration:

To ensure that it remains current and relevant, the CNS program must be formally evaluated regularly (e.g., every 5 years, or more frequently as certification or national standards are updated/revised, or as major changes in the program/curriculum occur). Data from such evaluations, and the need to be responsive to changes in certification or national standards, are essential to guide decisions on refinements that may be needed to provide quality education that prepares graduates for effective practice in the CNS role.

Documentation (Required):

- Sample reports of data collection activities.
- Examples of how outcome data have been used to revise/refine the CNS program.

5-5. Faculty who teach in the Clinical Nurse Specialist program are evaluated regularly, according to parent institution or nursing unit policies.

Elaboration:

To ensure that faculty continues to be appropriately credentialed effective teachers, current in their knowledge of CNS practice, and contributing professionals, there must be a plan for when, how, and by whom regular evaluations of all faculty who teach in the CNS program are conducted.

Documentation (Required):

- Methods used to evaluate faculty who teach in the CNS program (for example, annual activity reports, student evaluations of teaching effectiveness, and peer evaluations of teaching and scholarship).

- Description of when faculty teaching in the CNS program are evaluated, by whom, and how data from those evaluations are used to promote ongoing faculty development and program quality.
- Tools/instruments used to gather evaluative data about faculty who teach in the CNS program.

5-6. The clinical agencies and preceptors utilized for the Clinical Nurse Specialist program are evaluated annually by faculty members and students.

Elaboration:

There must be clearly defined processes and methods to evaluate the effectiveness and appropriateness of clinical sites, and the qualifications and effectiveness of preceptors engaged in supervising and evaluating CNS students.

Documentation (Required):

- Description of procedures and methods used by students enrolled and faculty teaching in the CNS program to evaluate clinical facilities used in the program.
- Description of how clinical facilities, including those in locations for distance-education students, are selected and evaluated.
- Description of procedures and methods used by students enrolled in and faculty teaching in the CNS program to evaluate the preceptors involved in supervising and evaluating students.
- Tools/instruments used to gather evaluative data about clinical facilities used and preceptors who supervise and evaluate CNS students.

5-7. Evaluation of students is cumulative, multi-method, and incorporates clinical observation of performance by faculty who teach in the Clinical Nurse Specialist program and preceptors who supervise students in practice experiences.

Elaboration:

Student performance must be evaluated overall and should include an evaluation in each clinical course according to a defined evaluation plan. Such evaluations should be comprehensive, use multiple means to gather data about performance, and include observations (in-person, virtually, or through the use of various technologies) of students' performance by the faculty member teaching the CNS clinical course and the preceptor who provides ongoing supervision of the student in the clinical facility.

Documentation (Required):

- Description of the plan for evaluating student performance, including the methods used to evaluate clinical performance, the frequency of evaluations, and the responsibilities of faculty and preceptors in the evaluation process.
- Description of how feedback is provided to students by faculty and preceptors regarding their performance, and their progress in meeting program outcomes/competencies.

Documentation (Recommended):

- Examples of the tools/instruments used to evaluate students' performance in the CNS program, including didactic and clinical courses.

REFERENCES

- Advanced Practice Registered Nurse (APRN) Consensus Work Group (2008). *Consensus model for APRN licensure, accreditation, certification and education*. Retrieved from: <https://nacns.org/advocacy-policy/advocacy-resources/state-public-policy-resources/>
- Altmiller, G. (2011). Quality and safety education for nurses' competencies and the clinical nurse specialist role. *Clinical Nurse Specialist*, 25, 28-32.
- American Association of Colleges of Nursing (AACN). (1994). *Annual report: Unifying the curricula for advanced practice nursing*. Washington, DC: Author.
- American Association of Colleges of Nursing (AACN). (1996). *The essentials of master's education for advanced practice nursing*. Washington, DC: Author.
- American Association of Colleges of Nursing (AACN). (2006). *The essentials of doctoral education for advanced nursing practice*. Washington, DC: Author.
- American Association of Colleges of Nursing (AACN). (2011). *The essentials of master's education in nursing*. Washington, DC: Author.
- American Association of Colleges of Nursing (AACN). (2017). *Common advanced practice registered nurse doctoral-level competencies*. Washington, DC: Author.
- American Association of Colleges of Nursing (AACN) Quality and Safety Education for Nurses (QSEN) Education Consortium. (2012). *Graduate-level QSEN competencies, knowledge, skills and attitudes*. Washington, DC: Author.
- American Association of Critical-Care Nurses. (2018). Get certified. Retrieved from: <https://www.aacn.org/certification/get-certified>
- American Nurses Association (ANA). (1996). *Scope and standards of advanced practice registered nursing*. Washington, DC: Author.
- American Nurses Association (ANA). (2004). *Nursing: Scope and standards of practice*. Washington, DC: Author.
- American Nurses Association (ANA). (2010). *Nursing's social policy statement. (3rd ed.)*. Washington, DC: Author.
- American Nurses Association (ANA). (2014). Professional role competence. Retrieved from: <https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/professional-role-competence/>
- American Nurses Association (ANA). (2015). *Code of ethics for nurses with interpretive statements*. Washington, DC: Author.
- American Nurses Association (ANA), Council of Clinical Nurse Specialists. (1986). *The role of the clinical nurse specialist*. Washington, D.C.: Author.
- American Nurses Credentialing Center (ANCC). (2018). Our certifications. Retrieved from <https://www.nursingworld.org/our-certifications/>
- APRN Joint Dialogue Group. (2008). *Consensus model for APRN regulation: Licensure, accreditation, certification, & education*. Retrieved from: https://www.ncsbn.org/Consensus_Model_Report.pdf
- Baldwin, K.M., Lyon, B.L., Clark, A. P., Fulton, J., Davidson, S., & Dayhoff, N. (2007). Developing clinical nurse specialist practice competencies. *Clinical Nurse Specialist*, 21(6), 297-303.
- Bigbee, J. L., & Amidi-Nouri, A. (2000). History and evolution of advanced nursing practice. In A. B. Hamric, J. A. Spross, & C. M. Hanson (Eds.), *Advanced nursing practice: An integrative approach* (2nd ed.). Philadelphia: W. B. Saunders.
- Boyd, N. J., Stasiowski, S. A., Catoe, P. T., Wells, P. R., Stahl, B. M., Judson, E., ... & Lander, J.H. (1991). The merit and significance of clinical nurse specialists. *Journal of Nursing Administration*, 21(9), 35-43.
- Burns, P., Nishikawa, J., Weatherby, F., Forni, P., Moran, M., Allen, M.,... & Booten, D. A. (1993). Master's degree nursing education: State of the art. *Journal of Professional Nursing*, 9, 267-276.
- Englander, R., Cameron, T., Ballar, A. J., Dogen, J., Bull, J., & Aschenbrener, C. A. (2013). Toward a taxonomy of competency domains for health professions and competencies for physicians. *Academic Medicine*, 88(8), 1088-1094.
- Fenton, M. V. (1985). Identifying competencies of clinical nurse specialists. *Journal of Nursing Administration*, 15(12), 31-37.
- Fulton, J. S. (2014). Evolution of the clinical nurse specialist role and practice in the United States. In J. S. Fulton, B. L. Lyon, & K. A. Goudreau (Eds.), *Foundations of clinical nurse specialist practice* (2nd ed., pp. 2-15). New York: Springer Publishing Company.
- Fulton, J. S., Mayo, A., Walker, J., & Urden, L. (2015). Core practice outcomes for clinical nurse specialists: A revalidation study. *Journal of Professional Nursing*, 32(4), 271-282.
- Georgopoulos, B. S., & Christman, L. (1970). The clinical nurse specialist: A role model. *American Journal of Nursing*, 70, 1030-1039.

- Georgopoulos, B. S., & Jackson, M. M. (1970). Nursing kardex behavior in an experimental study of patient units with and without clinical specialists. *Nursing Research*, 19, 196-218.
- Hamric, A. B. (1989). History and overview of the CNS role. In A. B. Hamric & J. A. Spross (Eds.), *The clinical nurse specialist in theory and practice* (2nd ed., pp. 3-18). Philadelphia: W. B. Saunders.
- Hansen, C. M., & Carter, M. (2014). Collaboration. In A.B. Hamric, C.M. Hansen, M.F. Tracy, & E.T. O'Grady (Eds.), *Advanced practice nursing: An integrative approach* (5th ed., pp.299-327). Philadelphia, PA: Elsevier.
- International Council of Nurses (ICN). (2008). *The scope of practice, standards, and competencies of the advanced practice nurse*. ICN regulatory series. Geneva, Switzerland: Author.
- Institute of Medicine (IOM) Committee on the Quality of Health Care in America. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.
- Interprofessional Education Collaborative. (2016). *Core competencies for interprofessional collaborative practice: 2016 update*. Washington, DC: Author.
- Koloroutis, M., & Trout, M. (2012). *See me as a person: Creating therapeutic relationships with patients and their families*. Minneapolis, MN: Creative Healthcare Management, Inc.
- Lynn, M. R. (1986). Determination and qualification of content validity. *Nursing Research*, 35(6), 382-386.
- Mayo, A. M., Harris, M., & Buron, B. (2016). Integrating geropsychiatric nursing and interprofessional collaborative practice competencies into adult-gerontology clinical nurse specialist education. *Clinical Nurse Specialist*, 30, 324-331.
- Mick, D., & Ackerman, M. H. (2002). Deconstructing the myth of the advanced practice blended role: Support for role divergence. *Heart & Lung*, 31(6), 393-398.
- National Association of Clinical Nurse Specialists (NACNS). (1998). *Statement on clinical nurse specialist practice and education*. Harrisburg, PA: Author.
- National Association of Clinical Nurse Specialists (NACNS). (2004). *Statement on clinical nurse specialist practice and education* (2nd ed.). Harrisburg, PA: Author.
- National Association of Clinical Nurse Specialists (NACNS). (2010). *Clinical nurse specialist core competencies executive summary, 2006-2008*. Harrisburg, PA: Author.
- National Association of Clinical Nurse Specialists (NACNS). (2015a). *Position statement on the doctor of nursing practice*. Retrieved from: <https://nacns.org/advocacy-policy/position-statements/position-statement-on-the-doctor-of-nursing-practice/>
- National Association of Clinical Nurse Specialists (NACNS). (2015b). *Scope of practice*. Retrieved from: <https://nacns.org/advocacy-policy/policies-affecting-cnss/scope-of-practice/>
- National Association of Clinical Nurse Specialists (NACNS). (2016). *Scope of practice*. Retrieved from: <https://nacns.org/advocacy-policy/policies-affecting-cnss/scope-of-practice/>
- National Association of Clinical Nurse Specialists (NACNS). (2017). *APRN factsheet*. Retrieved from: nacns.org/members/aprn-faqs/aprn-factsheet
- Page, N. E., & Arena, D. M. (1994). Rethinking the merger of the clinical nurse specialist and the nurse practitioner roles. *Image: Journal of Nursing Scholarship*, 24(4), 315-318.
- Peplau, H. (1965/2003). Specialization in professional nursing. *Clinical Nurse Specialist*, 17(1), 3-9.
- Pew Health Professions Commission. (1995). *Critical challenges: Revitalizing the health professions in the twenty-first century*. San Francisco, CA: University of San Francisco Center for Health Professions.
- Reiter, F. (1966). The nurse-clinician. *American Journal of Nursing*, 66(2), 274-280.
- Scott, K. & McSherry, R. (2009). Evidence-based nursing: Clarifying the concepts for nurses in practice. *Journal of Clinical Nursing*, 18(8), 1085-1095.
- Schroer, K. (1991). Case management: Clinical nurse specialist and nurse practitioner, converging roles. *Clinical Nurse Specialist*, 5(4), 189-194.
- Sparacino, P. S. A. (2000). The clinical nurse specialist. In A. B. Hamric, J. A. Spross, & C. M. Hanson (Eds.), *Advanced practice nursing: An integrative approach* (2nd ed., pp.381-405). Philadelphia, PA: Elsevier.
- Walker, J., Gerard, P. S., Bayley, E. W., Coeling, H., Clark, A. P., Dayhoff, N., & Goudreau, K. (2003). A description of clinical nurse specialist programs in the United States. *Clinical Nurse Specialist*, 17(1), 50-57.

APPENDIX A

Glossary of Key Terms

Clinical Nurse Specialist:

The Clinical Nurse Specialist (CNS) is an advanced practice registered nurse (APRN) with clinical expertise in a population focus with specialty expertise. “The CNS has a unique APRN role to integrate care across the continuum and through three spheres of impact: patient direct care, nurses/nursing personnel, organizations/systems. The three spheres are overlapping and interrelated, but each sphere has a distinctive focus. In each of the spheres of impact, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities” p. 8-9. (APRN Joint Dialogue Group Report, 2008).

Coaching:

Skillful guidance and teaching to influence behavioral changes by patients, families, and staff to improve outcomes.

Collaboration:

A dynamic-interpersonal process in which two or more individuals share responsibility and commit to accomplishing a shared goal through open, honest, and trustworthy interactions (Hansen & Carter, 2014).

Competency:

An expected level of performance that integrates knowledge, skills, abilities, and judgment (ANA, 2014).

Consultation:

Patient, nurse/healthcare professional, or system level problem-focused interactions between a CNS possessing specialized knowledge and expertise, and a consultee seeking expert recommendations.

Direct Care Sphere:

Direct interaction with patients, families, and groups of patients to promote health and well-being and improve quality of life. It is characterized by a holistic perspective in the advanced nursing management of health, illness, and disease states.

Diversity:

Identifies, acknowledges, and respects the unique differences among individuals and integrates this in tailoring the plan of care.

Ethical Decision-Making, Moral Agency, and Advocacy:

Ethical and advocacy concerns at the patient, family, healthcare professional, system, community, and public policy levels.

Evidence-Based Practice:

A decision-making and/or problem-solving process in which evidence, theory, clinical expertise, and patient preferences are critically evaluated and considered to provide delivery of optimum care and improve outcomes (Scott & McSherry, 2009).

Grandfathering/Grandfathering Clause:

This is a legal concept. It is a provision in law that allows an old rule's parameters to continue for a certain group (in certain situations) while a new rule is applied to all future cases. The grandfathered clause has no time limit or may be limited by time or circumstance.

Healthcare Policy:

Integrating knowledge of regulations, standards, and economics of healthcare to promote positive outcomes across the three spheres.

Leadership:

The ability to envision the need for change, influence, and encourage others to create change in clinical practice processes, policies, and outcomes within and across systems.

Nurses and Nursing Practice Sphere:

In this sphere, the CNS advances nursing practice to achieve optimal outcomes by ensuring that nurses and nursing personnel use evidence-based practices to meet the multifaceted needs of patients and/or populations.

Patient:

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

PICO:

An acronym for a system of questioning. It is often used to develop evidence-based clinical questions or to assist in performing a focused literature search. The “P” stands for patient or problem; the “I” stands for intervention; the “C” stands for comparison, and the “O” stands for outcome. Some refer to it as PICOT or PICOTT where the first “T” stands for *type of question* and the second “T” stands for *type of study*.

Organizations/Systems Sphere:

In this sphere, 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.

Quality Improvement and Safety:

Promoting, participating, and planning care services for individuals and populations that are clinically effective, efficient, safe, and outcome-driven.

Relationship-Centered Communication:

Communication strategies and behaviors that promote mutuality, shared understandings, and shared decision-making in healthcare encounters (Koloroutis & Trout, 2012).

Research:

The work of thorough and systematic inquiry. Includes the search for, interpretation, and use of evidence in clinical practice and quality improvement, and active participation in the conduct of research. The generation and dissemination of new knowledge through formal, systematic, and rigorous inquiry and methods.

Specialty Competency:

Clinical nurse specialist specialty practice builds on core competencies and represents an interpretation and integration of them in the knowledge and skills of the specialty (Baldwin et al, 2007).

Sphere of Impact:

A domain or area of CNS practice that reflects the pertinent stakeholders or consumers of CNS services. A particular sphere of impact includes the scope of practice, activities, and parameters of targeted outcomes.

Wellness:

Wellness is a subjective experience and is characterized by pleasant sensations and a perception of comfort. It can be experienced in the presence or absence of disease.

Consensus Model for APRN Licensure, Accreditation, Certification, and Education

The NACNS was involved in the nursing community’s development of the 2008 *Consensus Model of APRN Legislation, Accreditation, Certification, and Education* (APRN Consensus Work Group, 2008). The NACNS was one of the original signing organizations in support of the landmark regulatory guidance document. The drafting organizations understood that the document was based on consensus and the best understanding of the healthcare system and restraints for full practice authority for the APRN. There was an understanding that the power of bringing the entire APRN nursing community together to develop and support implementation of the document was powerful, and efforts were made to maintain the originally agreed-upon language through initial implementation.

As with any sweeping change, there are a number of unintended consequences with this document and issues in full adoption across the states. The NACNS continues to advocate for:

- Title protection for the CNS.
- Grandfathering of established CNSs when states implement the APRN Consensus Model.
- Modifications to the regulatory model that offer a method of licensure for CNSs under all population foci.
- An environment that allows the evolution of new or changed population foci and/or roles in the future.

To provide for full understanding of the issues addressed in the APRN Consensus Model, pages 7-11 of the model, as published in 2008, is included below.

APPENDIX B

APRN REGULATORY MODEL

APRN Regulation includes the essential elements: licensure, accreditation, certification, and education (LACE).

- Licensure is the granting of authority to practice.
- Accreditation is the formal review and approval by a recognized agency of educational degree or certification programs in nursing or nursing-related programs.
- Certification is the formal recognition of the knowledge, skills, and experience demonstrated by the achievement of standards identified by the profession.
- Education is the formal preparation of APRNs in graduate degree-granting or post-graduate certificate programs.

The APRN Regulatory Model applies to all elements of LACE. Each of these elements plays an essential part in the implementation of the model.

Definition of Advanced Practice Registered Nurse

Characteristics of the advanced practice registered nurse (APRN) were identified and several definitions of an APRN were considered, including the NCSBN and the American Nurses Association (ANA) definitions, as well as others. The characteristics identified aligned closely with these existing definitions. The definition of an APRN, delineated in this document, includes language that addresses responsibility and accountability for health promotion and the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions.

The definition of an Advanced Practice Registered Nurse (APRN) is a nurse:

1. who has completed an accredited graduate-level education program preparing him/her for one of the four recognized APRN roles;
2. who has passed a national certification examination that measures APRN, role and population-focused competencies and who maintains continued competence as evidenced by recertification in the role, and population through the national certification program;
3. who has acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients, as well as a component of indirect care; however, the defining factor for **all** APRNs is that a significant component of the education and practice focuses on direct care of individuals;
4. whose practice builds on the competencies of registered nurses (RNs) by demonstrating a greater depth and breadth of knowledge, a greater synthesis of data, increased complexity of skills and interventions, and greater role autonomy;
5. who is educationally prepared to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions;
6. who has clinical experience of sufficient depth and breadth to reflect the intended license; **and**
7. who has obtained a license to practice as an APRN in one of the four APRN roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), or certified nurse practitioner (CNP).

Advanced practice registered nurses are licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. Each APRN is accountable to patients, the nursing profession, and the licensing board to comply with the requirements of the state nurse practice act and the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience, planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other healthcare providers as appropriate.

All APRNs are educationally prepared to provide a scope of services across the health wellness-illness continuum to at least one population focus as defined by nationally recognized role and population-focused competencies; however, the emphasis and implementation within each APRN role varies. The services or care provided by APRNs is not defined or limited by setting but rather by patient care needs. The continuum encompasses the range of health states from homeostasis (or wellness) to a disruption in the state of health in which basic needs are not met or maintained (illness), with health problems of varying acuity occurring along

the continuum that must be prevented or resolved to maintain wellness or an optimal level of functioning (WHO, 2006). Although all APRNs are educationally prepared to provide care to patients across the health wellness-illness continuum, the emphasis and how implemented within each APRN role varies.

The Certified Registered Nurse Anesthetist

The Certified Registered Nurse Anesthetist is prepared to provide the full spectrum of patients' anesthesia care and anesthesia-related care for individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites and obstetrical delivery rooms; critical access hospitals; acute care; pain management centers; ambulatory surgical centers; and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons.

The Certified Nurse-Midwife

The certified nurse-midwife provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, childbirth, and care of the newborn. The practice includes treating the male partner of their female clients for sexually transmitted disease and reproductive health. This care is provided in diverse settings, which may include home, hospital, birth center, and a variety of ambulatory care settings including private offices and community and public health clinics.

The Clinical Nurse Specialist

The CNS has a unique APRN role to integrate care across the continuum and through three spheres of influence: patient, nurse, system. The three spheres are overlapping and interrelated but each sphere possesses a distinctive focus. In each of the spheres of influence, the primary goal of the CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress, facilitate ethical decision-making, and respond to diversity. The CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities.

The Certified Nurse Practitioner

For the certified nurse practitioner (CNP), care along the wellness-illness continuum is a dynamic process in which direct primary and acute care is provided across settings. CNPs are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics, and women's health care. CNPs are prepared to diagnose and treat patients with undifferentiated symptoms as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing, and comprehensive care, includes taking comprehensive histories, providing physical examinations and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. Clinical CNP care includes health promotion, disease prevention, health education, and counseling as well as the diagnosis and management of acute and chronic diseases.

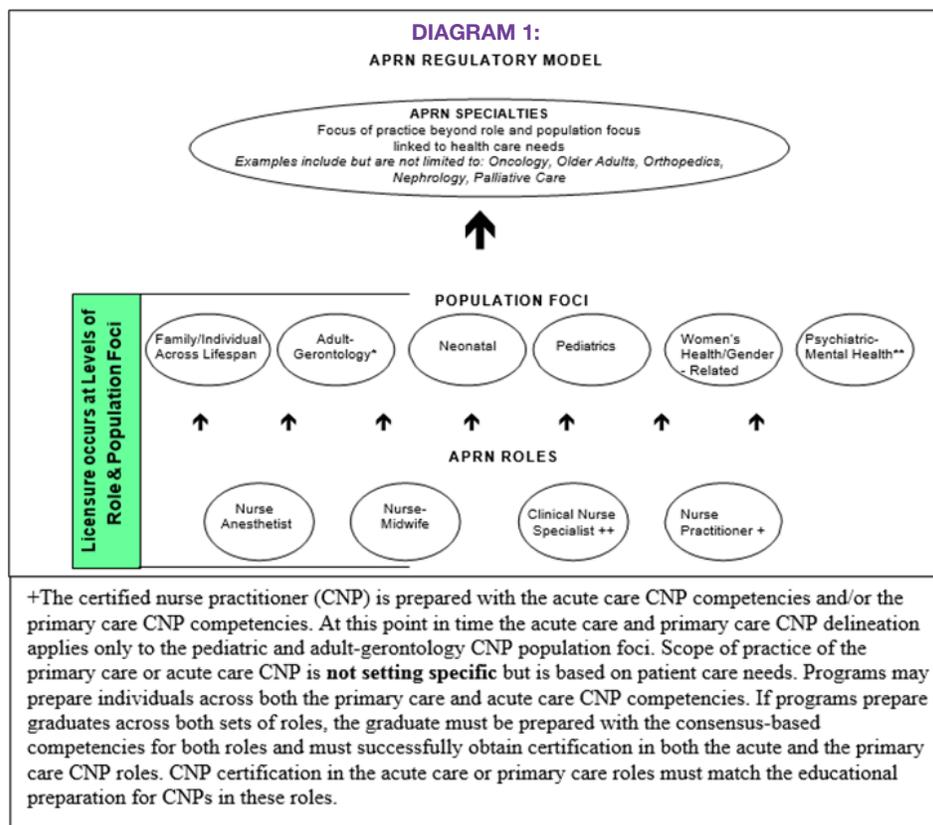
Certified nurse practitioners are prepared to practice as primary care CNPs and acute care CNPs, which have separate national consensus-based competencies and separate certification processes.

TITLING

The title Advanced Practice Registered Nurse (APRN) is the licensing title to be used for the subset of nurses prepared with advanced, graduate-level nursing knowledge to provide direct patient care in four roles: certified registered nurse anesthetist, certified nurse-midwife, clinical nurse specialist, and certified nurse practitioner.⁴ This title, APRN, is a legally protected title. Licensure and scope of practice are based on graduate education in one of the four roles and in a defined population.

Verification of licensure, whether hard copy or electronic, will indicate the role and population for which the APRN has been licensed.

At a minimum, an individual must legally represent themselves, including in a legal signature, as an APRN and



by the role. He/she may indicate the population as well. No one, except those who are licensed to practice as an APRN, may use the APRN title or any of the APRN role titles. An individual also may add the specialty title in which they are professionally recognized in addition to the legal title of APRN and role.

Diagram 1: APRN Regulatory Model (above)

Under this APRN Regulatory Model, there are four roles: certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). These four roles are given the title of advanced practice registered nurse (APRN). APRNs are educated in one of the four roles and in at least one of six population foci: family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women's health/gender-related or psych/mental health. Individuals will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci. Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they can not be licensed solely within a specialty area. Specialties can provide depth in one's practice within the established population foci.

* The population focus, adult-gerontology, encompasses the young adult to the older adult, including the frail elderly. APRNs educated and certified in the adult-gerontology population are educated and certified across both areas of practice and will be titled Adult-Gerontology CNP or CNS. In addition, all APRNs in any of the four roles providing care to the adult population, e.g., family or gender specific, must be prepared to meet the growing needs of the older adult population. Therefore, the education program should include didactic and clinical education experiences necessary to prepare APRNs with these enhanced skills and knowledge.

** The population focus, psychiatric/mental health, encompasses education and practice across the lifespan.

++ The Clinical Nurse Specialist (CNS) is educated and assessed through national certification processes across the continuum from wellness through acute care.

⁴ Nurses with advanced graduate nursing preparation practicing in roles and specialties that do not provide direct care to individuals and, therefore, whose practice does not require regulatory recognition beyond the Registered Nurse license granted by state boards of nursing may not use any term or title which may confuse the public, including advanced practice nurse or advanced practice registered nurse. The term advanced public health nursing however, may be used to identify nurses practicing in this advanced specialty area of nursing.

Broad-based APRN Education

For entry into APRN practice and for regulatory purposes, APRN education must:

- be formal education with a graduate degree or post-graduate certificate (either post- master's or post-doctoral) that is awarded by an academic institution and accredited by a nursing or nursing-related accrediting organization recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA);
- be awarded pre-approval, pre-accreditation, or accreditation status prior to admitting students;
- be comprehensive and at the graduate level;
- prepare the graduate to practice in one of the four identified APRN roles;
- prepare the graduate with the core competencies for one of the APRN roles across at least one of the six population foci;
- include at a minimum, three separate comprehensive graduate-level courses (the APRN Core) in:
 - Advanced physiology/pathophysiology, including general principles that apply across the lifespan;
 - Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts and approaches; and
 - Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents.
- Additional content, specific to the role and population, in these three APRN core areas should be integrated throughout the other role and population didactic and clinical courses;
- Provide a basic understanding of the principles for decision making in the identified role;
- Prepare the graduate to assume responsibility and accountability for health promotion and/or maintenance as well as the assessment, diagnosis, and management of patient problems, which includes the use and prescription of pharmacologic and non-pharmacologic interventions; and
- Ensure clinical and didactic coursework is comprehensive and sufficient to prepare the graduate to practice in the APRN role and population focus.

Preparation in a specialty area of practice is optional but if included must build on the APRN role/population-focus competencies. Clinical and didactic coursework must be comprehensive and sufficient to prepare the graduate to obtain certification for licensure in and to practice in the APRN role and population focus.

As part of the accreditation process, all APRN education programs must undergo a pre- approval, pre-accreditation, or accreditation process prior to admitting students. The purpose of the pre-approval process is twofold: 1) to ensure that students graduating from the program will be able to meet the education criteria necessary for national certification in the role and population-focus and if successfully certified, are eligible for licensure to practice in the APRN role/population-focus; and 2) to ensure that programs will meet all educational standards prior to starting the program. The pre-approval, pre-accreditation or accreditation processes may vary across APRN roles.

APPENDIX C

Content Validation Participants

American Association of Colleges of Nursing
Joan Stanley, PhD

American Association of Critical-Care Nurses
Elizabeth Scruth, PhD, MPH, CCRN, CCNS, FCCM

AACN Certification Corporation
Laura McNamara, RN, MSN, CCNS, CCRN-K

Academy of Medical-Surgical Nurses
Elizabeth Thomas, MSN, RN, ACNS-BC

American Nurses Association
Seun Ross, DNP, MSN, CRNP-F, NP-C, NEA-BC

American Nursing Credentialing Center
Diane Tompkins, MS, RN

American Pediatric Nurses Association
Carolyn Ross, MPRN, PN-BC

American Psychiatric Nurses Association
Gail R. Stern, RN, MSN, PMHCNS-BC

Association of Pediatric Hematology/Oncology Nurses
Kathy Patterson Kelly, PhD, APRN, PCNS-BC, CPON

Association of periOperative Registered Nurses
Laila Shiharo Bailey, DNP, MSN, RN, CNS, CNOR,
ACNS-BC

*Association of Women's Health, Obstetric and
Neonatal Nurses*
Major Amber Barker, MSN, APRN, WHNP-BC,
RNC-OB

Commission on Collegiate Nursing Education
Mary Jane S. Hanson, PhD, CRNP, CNS, FNP-BC,
ACNS-BC, FAANP

Einstein Healthcare Network
Charlene Griffith, MSN, APRN, ACNS-BC

Emergency Nurses Association
Carla Brim, MN, RN, CNS, CEN, PHCNS-BC, FAEN

Ft. Belvoir Community Hospital
Jacqueline Williams, RN

Hospice and Palliative Nurses Association
Bob Parker, DNP, RN, CENP, CHPN, CHP

National Association of Clinical Nurse Specialists
Ann Busch, MS, RN, CWOCN, ACNS-BC, CNS-PP,
FCNS, FAAN

National Association of Clinical Nurse Specialists
Angela Clark, PhD, RN, CNS, FAAN, FAHA

National Association of Clinical Nurse Specialists
Sheron Y. Campbell, LCDR, NC, USN, MS, BSN,
CCNS

National Association of Neonatal Nurses
Lori Brittingham, MSN, RN, CNS, ACCNS-N

National League for Nursing
Linda Moneyham, PhD, RN, FAAN

National League for Nursing CNEA
Judy Halstead, PhD, RN, ANEF, FAAN

Preventive Cardiovascular Nurses Association
Lola Coke, PhD, ACNS-BC, FAHA, FPCNA, FAAN

Oncology Nurses Society
Chelsea Backler, MSN, APRN, AGCNS-BC, AOCNS



11130 Sunrise Valley Drive
Suite 350
Reston, Virginia 20191

P 703.436.0092
E info@nacns.org
www.nacns.org