An exploratory audit: Original work

The Scope and Variance of Clinical Nurse Specialists Job The Scope and Variance of Clinical Nurse Specialists Job Descriptions: Still a Dilemma?

Abstract

Specialist nurses have been part of the nursing workforce for decades but articulating the scope of such roles, educational requirements, professional expertise and levels of pay is still widely debated within the workplace.

This paper examines a sample of Clinical Nurse Specialist's job descriptions (JD's), from across the United Kingdom. One hundred job descriptions (n=100) were attained, originating from varying health care settings and audited to explore their scope and content.

In conclusion, the job descriptions showed a high level of agreement of the scope domains of a clinical nurse role but were less consistent when considering experience and educational requirements of Clinical Nurse Specialists.

Key words:
Nursing, Clinical Nurse Specialist, Scope of practice, Core competencies, Variance.

Background

Specialist roles in the United Kingdom

Clinical Nurse Specialist (CNS's) roles in the United Kingdom (UK) have been in existence and debated for decades (HEE 2017, Humphris 1994, Mills & Pritchard 2004, NHSE 2013, NHSE 2016, NHSE & NHSI 2019 NMC 2020, RCN 2018, Vidall et al 2011).

Variations in the roles seem to remain widespread, accompanied by diverse clinical roles across healthcare settings, with various titles, educational requirements and pay (Mills & Pritchard 2004).

There are several definitions of “Clinical Nurse Specialists” (Affara and Styles 1992, Affara 2009, Devine 2017, RCN 2009). Over ten years ago, The Royal College of Nursing (2009) suggested that Clinical Nurse Specialists and Nurse Practitioners should be educated to at least degree level. Furthermore, they should also possess specialist knowledge, skills, competencies and experience, with key role components including: clinical focus, consultancy, involvement in education, research, liaison and administration. In practice there is some consistency among Clinical Nurses (CNS) who act as key workers, attend multi-professional meetings and enhance patient experiences. However these roles can be specific to individual jobs and local service issues and provide a wide range of services. The variation in CNS job titles and roles; has also evolved with a consistent level of advanced practice and educational structures and provision (HEE 2017, RCN 2018). Yet despite this, roles have not always been clearly defined (Affara 2009, Mohr and Coke 2018).

Clinical Nurse Specialist (CNS) roles developed steadily in the UK as a response to the publication of *The Scope of Professional Practice* by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC 1992) and the subsequent NHS plan (DoH 2000a). Today the role is well integrated into the healthcare environment. They work closely with multidisciplinary teams, to plan services and deliver programmes of care, which reflect patients’ complex needs (HEE 2017,Macmillan 2002, NHSE 2013, NHSE 2016, Vidall et al 2011).

The RCN in 2009 describe the need to provide opportunity for the experienced nurse to extend their role across patient pathways and begin to influence at both local and

national, strategic levels. It is suggested that Clinical Nurse Specialists should be: educated to at least Masters (MSc/MA) level, ideally a Doctorate (PhD) level, and exhibit up-to-date specialist knowledge, research, political, operational and clinical skills. Key role components should include: expert practice, leadership, education and research (RCN 2009). However, Clinical Nurse Specialists, ideally educated to an MSC/MA/PhD level may not always be evident in practice. Usually a degree or the willingness to work towards a Master's qualification appears to be a more widespread approach, depending on the institution. The guidance therefore from a decade ago appears no longer to be the current school of thought (Cooper et al 2019).

The numbers of Clinical Nurse's Specialist roles as well as the skills, competency and complexity of such roles has increased markedly with these roles being incorporated into multidisciplinary teams (Mohr and Coke 2018). The rise of specialisation in healthcare, a developing interface between primary and secondary care, the reduction in junior doctors' hours have contributed to the expansion of opportunities for nursing roles (Affara 2009, RCN 2009, Vidall et al 2011, NHSE 2016, NHSE & NHSI 2019). The development and emergence of CNS roles has taken place in the absence of any clear national definition of roles. The result is an array of titles with no generic frameworks for practice or comprehensive regulation at this level (Daly & Carnwell 2003).

Twenty years ago the United Kingdom Central Council (UKCC) attempted to address the difference between a nurse working in a specialism and a specialist nurse by focusing on 'higher-level practice' (UKCC, 1999), but further guidance is sparse. The National Health Service, "Agenda for Change" (2004) established a national competency-based framework through its new terms and conditions of service for

most job roles within the NHS, but this did not add clarity to the role definition. A further guide to the role function of specialist posts was outlined in the Chief Nursing Officer's *Ten Key Roles for Nurses* (DoH, 2000b) which provided a list of possible roles that a CNS may undertake. Macmillan (2010) summarised the impact of CNS roles in four main key areas. These are:

- Improving quality and experience of care for patients and their carers
- Reinforcing safety
- Increasing productivity and efficacy in delivering care
- Demonstrating leadership

In (2017) Health Education England introduced the 'Multi-professional framework for advanced clinical practice', advocating a more standardised educational approach to reduce the variation amongst specialist and advanced practitioners. These key areas of practice include: clinical practice, leadership and management, education and research, providing more consistency in approach (HEE2017).

In 2020, only two types of post-registration specialist training programmes are registered or recorded with the Nursing and Midwifery Council (NMC). These are:

- The Specialist Community Public Health Nurses (SCPHN) are registered on part of the NMC Register.
- Specialist Practice Qualification - nurses working in either hospital or community settings and specialising in areas of practice with qualifications recorded next to their entry level qualifications.

Whilst there is a requirement for a first level registration for the two roles, the NMC (2020) describes a 'period of experience of sufficient length' which seems to vary

across specialities and roles. Entry level for Specialist Community Public Health Nursing (SCPHN) programmes appear flexible, requiring no minimum period of post-registration. Post registration policies and standards are currently being reviewed and the present arrangements and advice are due to change by 2023 (NMC 2020).

A lack of a professional framework has led to the development of many Clinical Nurse Specialist roles being left to organisational governance. An Advanced Practitioner credential programme and register has been established by the Royal College of Nursing, which practitioners may join at an additional cost, with some employers agreeing to pay (RCN 2018).

Clinical Nurse Specialists; An international perspective

The United Kingdom experience is not unique. A Clinical Nurse Specialist may be integral to many of our patients' care pathways, although there is little, 'uniformity in the evolution of nursing specialities with respect to role titles, scope of practice, education and practice standards, and paths of entry' (ICN 2009).

The International Council of Nurses (ICN) defines a competency framework for Clinical Nurse Specialists (ICN 2009) highlighting three areas or domains of practice but these have not been applied with consistency across the globe. These include:

- Professional, ethical and legal practice
- Care provision and management
- Professional, personal and quality development,

The role and title has been in use in the USA for decades (Baldwin et al 2007, Dunn 1997, Hamric, Spross & Hanson 2005) and as such, definitions of a CNS in other

parts of the world often originated from the US context. A systematic review by Donald et al (2014) found only limited evidence of the quality and effectiveness of CNS's within Randomised Controlled Trials (RCT's). These mainly originated in the USA and many of these studies were found to be qualitative and mixed method surveys or phenomenological studies, rather than RCT's. The review concluded that there is still considerable role confusion and ambiguity, despite the CNS role having been around in the USA for many decades.

In the Southern Hemisphere a similar picture emerges, New Zealand lacks national definition; the District Health Boards demonstrate limited areas of consensus regarding the essential requirements for the CNS role (Roberts, Floyd & Thompson 2011). There are inconsistencies in how the roles are defined, most notably concerning requirements for postgraduate qualifications and professional development recognition programmes (Brook & Rushforth 2011, Manias Happel & Elsom 2006, Sanchez et al 2019). The CNS role is inconsistently defined particularly with respect to the postgraduate qualifications required and what is meant by 'expertise' (Roberts, Floyd &Thompson 2011). Studies have demonstrated the impact of the CNS in patient pathways (Macmillan 2010, RCN 2010, Vidall et al 2011) providing evidence of improving patient outcomes and providing effective and efficient care (RCN 2010, Vidall et al 2011,).

Investing in CNS's to perform routine consultation, follow–up appointments demonstrate time is released to see new patients and can be seen as cost efficient (Lopatina et al 2017, Macmillan 2002).

A review of the global literature by the research team highlighted five themed domains which appear to be repeated globally in the construction and regulation of

nursing roles, including the Clinical Nurse Specialist. There is recognition that the emphasis on these domains is not always equal in practice. These include: clinical practice (which includes direct patient care, delivery of care, despite location), leadership, education training and development, research and improvement and professional and ethical practice (ANA 2010, Baldwin et al 2009, Bryant-Lukosius et al 2004, Chiarella et al 2008, Glenn 2004, ICA 2009, Jokiniemi, Meretoja & Pietila 2018, Mills & Pritchard 2004, NMC 2017, Redekopp 1997, Vidall et al 2011, Wickham 2013). Within each domain, three sub-categories were further identified within the literature and utilised as core components. These are illustrated in **(Table 1.0)**

Table: 1.0.

Core role domains and their sub-categories

Dimension	Subcategories #1	Subcategory #2	Subcategory 3#
Clinical practice	A clinical area of practice	Communication skills	Teamwork and collaboration
Leadership	Leadership qualities and behaviours	Quality improvement and safety	supervision of others
Education training and development	Sharing Knowledge and teaching other healthcare professionals	Lifelong learning and self-development.	Promotion of health to patients and their families.
Research and Improvement	Evidence based practice – using evidence in daily practice.	Using technology to enhance patient care	participating in research
Professional and ethical practice	Accountability of a professional nurse, adherence to the NMC code of conduct. Attitude, professionalism , maintaining registration	Ethical practice Working as a professional nurse within the scope of professional practice. Patient advocate	Legal implications Expectation of parameters as a professional nurse, practicing within competences, law

Aims

This audit aimed to explore the parity of scope and content from a sample of Clinical Nurse Specialist's job descriptions within the United Kingdom. Advice was sought from local Research and Development experts and it was deemed that no ethics approvals were required as the project was categorised as an exploratory and evaluative audit (HRA 2017).

Method

Stage 1

From September 2017 to January 2019, one hundred job descriptions (JD's) acquired from genuine advertised roles, on-line were systematically attained, without bias from different NHS and health care organizations, throughout the United Kingdom. These included: Acute, Primary Trusts and local Authority, privately and charity funded organisations (for example hospices).

All of the JD's were externally advertised in public domains to recruit "Nurse Specialist" posts within varying clinical specialities. The names of the organisations/providers were not relevant to the project and therefore were not used in any form to identify them. The only form of identification was with regard to speciality and type of provider. Each JD was numbered, sequentially. These were then stored electronically and shared between the reviewing authors, who then reviewed each individual JD, completing an audit tool template. One hundred samples were chosen in this first instance as this was perceived to be a manageable, practical number to deal with considering time lines of organising JD's, reviewing, discussing, analysing and writing up results.

Stage 2

An audit template or tool was developed to facilitate the assessment process by our authors**.** The audit tool contents were derived from our review of the literature, professional experience and discussions within the group with regard to organisation and relevance to the task.

The template tool included: a job description number for each JD, area/speciality of practice (e.g. surgery), qualifications and experience required (e.g. specified within the specific JD under review) followed by five identified clinical dimensions and subcategory headings **(Table 1.0).**

Stage 3

Three, Registered Nurse assessors, (AMC, PR and VC) independently reviewed each of the 100 JD's. Experience, qualifications and areas of speciality were coded. Correspondence between the three was undertaken by E-mail, teleconference and some face to face meetings. Each sub category was assessed and marked either present (n=1) absent (n=0) within the template. Assessors used their nursing expertise to interpret meaning and to record the inclusion of the subcategories within the job descriptions. Each assessor had their own electronic spread sheet template to complete.

When completed, Assessors 1 (AMC) and 2 (PR) discussed and compared their assessments of each of the Job descriptions. Differences of opinion with regard to the assessments were discussed, negotiated and then agreed upon; producing a third completed combined audit spread sheet (Template 3). Assessor 3 (VC) independently reviewed and assessed the 100 JD's forming (Template 4). This was then compared with the agreed joint template from Assessors 1 and 2 (Template 3). Differences of opinion were discussed and negotiated until a final merged template was agreed and ready for analysis forming the final audit spread sheet 5 (Combining Authors 1,2,3 assessments).

Findings

One hundred Job descriptions were reviewed, utilising a pre-determined template audit tool of core identified domains and subcategories **(Table1.0)**.

The JD samples originated from primary, secondary, local authority, private and charity funded providers / organisations within varying clinical specialities, these were sourced electronically from within UK from genuine job advertisements.

The two most frequent speciality areas were Palliative care (n=27) and Surgery (n=23) **(Table 2.0).**

No deliberate discriminations with regard to inclusion / exclusion criteria's were considered for the project. There were 63, Job descriptions acquired from Acute Trust's, 11 from charity funded Hospice's, 24 from Community Providers and 2 used from Private care providers (mental health).

Table 2.0

A breakdown of number of Job description by clinical speciality

Area Code	**% of Total**
Community	3
Emergency care specialities	1
Generic (no speciality cited)	2
Haematology/ Oncology	10
Medical specialities	9
Mental health	9
Neurology	8
Ophthalmology	2
Palliative Care	27
Paediatrics specialities	3
Rheumatology	1
Safeguarding	1
Surgery specialities	23
Tissue Viability	1
Total = 100	

All Job descriptions and two of the largest represented subgroups (palliative care and surgical specialities) are presented for review. There were variations in the essential qualifications identified within the job descriptions; overall 33% did not specify the qualifications that the organisation expected for their CNS role. All JD's specified that the applicants must be an active registered nurse. N=100 **(Table 3.0).**

Table 3.0

Sample of required qualifications specified within CNS job descriptions

Qualifications	All JDs	Palliative Care	Surgery
RN registration	100%	100%	100%
BSc	12.0%	15.0%	9.0%
BSc and Post Registration Qualification' s	53.0%	48.0%	50.0%
MSc/ MA	2.0%	0.0%	0.0%
Not Specified	33.0%	37.0%	41.0%

The levels of experience required by care providers within the samples of JD's were segmented into three groups. These were: substantial experience (5 or more years) experience, less than 5 years' experience requested and no experience specified groupings. The levels of essential experience varied across the job descriptions **(Table 4.0).**

Table 4.0

Sample of levels of experience requested within each JD sampled, presented as percentages

Experience	All JDs	Palliative Care	Surgery
Substantial amount of experience 5years plus +	36.0%	37%	32%
Minimal amount of experience less than 5 years	31.0%	30.0%	32.0%
No experience specified	33.0%	33.0%	36.0%

The five identified clinical role domains with their sub categories show less variation than qualifications and experience.

Clinical practice was the only domain, which was included in all of the JD'S (100%). The use of technology to enhance patient care and promotion of health to patients and their families, both recorded at 71%, was the least mentioned dimension. The majority of scores were in the 90% range indicating a high level of similarity and parity amongst the samples audited **(figure 5.0)**.

Table 5.0

Core clinical domains and their sub categories recorded as percentages

Dimension	Subcategories #1	Subcategory #2	Subcategory 3#
Clinical practice	A clinical area of practice **100%**	Communication skills **95%**	Teamwork and collaboration **97%**
Leadership and management	Leadership qualities and behaviours 95%	Quality improvement and safety 91%	Delegation and supervision of others 82%
Education training and development	Sharing Knowledge and teaching other healthcare professionals **93%**	Lifelong learning and self-development. **88%**	Promotion of health to patients and their families. **71%**
Research and Improvement	Evidence based practice – using evidence in daily practice. **99%**	Using technology to enhance patient care **71%**	Developing and participating in research **80%**
Professional and ethical practice	Accountability of a professional nurse, adherence to the NMC code of conduct. Attitude, professionalism , maintaining registration **91%**	Ethical practice Working as a professional nurse within the scope of professional practice. Patient advocate **86%**	Legal implications Expectation of parameters as a professional nurse, practicing within competences, law **77%**

Discussion.

The review of Clinical Nurse Specialists job descriptions highlighted that job descriptions templates and the descriptive language used was diverse, but the

scope showed a high level of agreement of the role dimensions rating from 71%-100%.

The new undergraduate programme for nurse registration (NMC 2018) highlights the changing world of practice and how nursing roles are being redefined to enhance patient care. The use of technology in future healthcare will expand as innovation provides new and exciting ways of treatment and the involvement of patients' in their own care. The domains interconnect and the opportunities for example that technology will bring to enhance health promotion and teaching with patients about their healthcare needs may place greater emphasis in future Clinical Nurse Specialist's job descriptions.

The domains highlighted could also be used to map many nursing roles, but the level of practice should also be linked to the level of qualification and practice competence. The qualification requirements in the job descriptions showed high levels of variation with 33% of job descriptions not stipulating additional post registration qualifications. Critical thinking, clinical knowledge and competence are evidenced in our society with a level of accredited education or qualifications and this is worth future consideration. Large variations may be due to shortages of nurses, but a range of expected post registration education may help professional practice and organisational governance which would further enhance public protection and confidence. Experience is another component that requires consideration, whilst translational skills can be learnt; guidance may assist levels of variation. Experience doesn't necessitate competency. It is also acknowledged that different candidates will bring different experience and qualities to a role.

Only 100 job descriptions were examined from across the UK within this audit which is limited. However, job descriptions themselves have limitations in understanding the depth and breadth of these multifaceted roles. Replication of this work on a larger scale could be undertaken nationally and even internationally, which could build on this work to provide further clarity on role components. This would also provide a reference point or framework to ensure continuity and parity amongst this professional group and set the standard with regard to quality. Nurse shortages may have exacerbated this situation in an attempt to retain talented staffs that have much potential in their professional roles. There is no simple solution but parity with regard to job descriptions and career frameworks would help create a streamlined and unified approach. A national repository of job description templates, which can then be localised could be the answer to ensure a consistent approach. This is needed when dealing with the scope of roles, titles, educational requirements, professional expertise and levels of pay in the workplace as well as a career structure. This approach would consider an individual's developmental needs, education and a willingness to adapt and learn.

Consistency of Clinical Nurse Specialist's roles can enhance the profile of the role, quality of training and competencies along with enhancing public understanding and the quality of care. This is a complex issue, but providing more guidance will strengthen the much needed high level of consistency that can already be seen in UK job descriptions. Perhaps consideration could be given in linking to the Code of Professional Conduct and revalidation to enable a structural framework to provide further guidance in the future.

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