Instrument Development for Measuring Perceptions of the Role of the Clinical Nurse Specialist

By

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A Master's Research Project

Presented to
Oregon Health Sciences University
School of Nursing
in partial fulfillment of
the requirements for the degree of
Master of Science

July 4, 1995

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ACKNOWLEDGMENTS

We are indebted to a number of people. Some were colleagues who contributed to the intellectual genesis, development, and completion of this project; some were friends who boosted our spirits and provided motivation instrumental for allowing us to complete this work.

The members of our committee, Joyce Crane and Sue Davidson, provided valuable criticism and assistance in the development of this project; from the proposal, through the design, to the refinement of the composite instrument.

We would like to thank the content and format experts who participated in this project. They were generous in offering their time and suggestions.

Our families and friends played a fundamental role in this work by providing us with encouragement through all phases of our graduate careers. Each of us would like to acknowledge special contributors to our project.

Nadine.

I am forever grateful to my husband and best friend, Russ, who remained my constant source of encouragement and managed far more than his share of household and parental responsibilities during my education. I also thank our two wonderful sons, Newlan and Calden, for their support, inspiration, and love. Finally, I would like to express my sincere appreciation to my research partner, Ramona, for a pluperfect (almost) experience.

Ramona.

I could have never made it to this point without the encouragement and support that Judy, Sandy, and Bob gave me in such large measure. My younger son, Paul, always expects that I will do well, and his positive regard buoys me. My older son, Scott, was a frequent source of knowledge, perspective, and support. He and my daughter-in-law, Karen, contributed invaluable technical expertise when it was critically needed. My thanks to Nadine, whose devotion and integrity always shine through. I love you all very much.

ABSTRACT

Title: Instrument Development for Measuring Perceptions of the Role of the Clinical Nurse Specialist

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The primary purpose of this project was to design a composite instrument to examine perceptions of the Clinical Nurse Specialist (CNS) role components, activities related to the role making process, and the influence of health care changes on the employment of the CNS in institutional settings. Content validity was established by content experts who had experience with the CNS role.

The project was conducted with a convenience sample of 3 nurse administrators (NAs) and 3 CNSs over approximately a 2-month period of time. The composite instrument was administered to each subject within a pre-scheduled period of 1 and 1/2 hours. The intent was to first gain an understanding of the length of time necessary to complete the questionnaire, to verify content validity of the tool, and to enable subjects to offer suggestions regarding clarity and feasibility of administration.

The composite instrument has 3 major sections. The first includes demographic data, as well as items relating to the changing health care environment. The second section consists of the Clifford Clinical Nurse Specialist Functions Inventory (CCNSFI) which measures perceptions of relative importance of specific CNS functions. The final section contains items developed by the authors for examining CNS role development within a role theory conceptual framework.

Recommendations for minor changes in the demographic questions of section one were incorporated. Revisions in wording for some items in the CCNSFI were made for

relevancy to today's changing health care environment. In the role processes section (section 3), questions relating to reassignment of CNSs were changed from closed to an open-ended format, due to lack of clarity. The composite tool was judged by the six content experts as feasible, with logical flow, and of reasonable length.

The next step of continued piloting of the instrument should include a pretest with 20 to 30 subjects. This, however, would largely utilize the available sample for future study in this northwest region. Given this, it is recommended that further validity and reliability testing be conducted simultaneously with a research study. A full study would allow comparison of perceptions of NAs and CNSs to determine if they systematically differ .

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CHAPTER ONE

Introduction and Statement of the Problem

The role of the clinical nurse specialist (CNS) originated after World War II in response to the growing need for a higher level of expert nursing (Sparacino, 1990). As the complexities in health care delivery have continued to expand, the CNS role has been implemented in a number of ways. The role has taken many forms in response to the need for specialization in a variety of clinical areas. For example, the CNS may function as a case manager with responsibility for coordination of complex care. Elsewhere, the CNS may become expert in the clinical practice role and focus on a highly specialized area such as enterostomal nursing. Consequently, each application of the CNS role may vary, based on institutional needs and individual CNS interpretation.

While this flexibility and adaptability of the CNS has been beneficial in many ways, it has also contributed to loosely defined boundaries and unclear role definition. This lack of clarity can lead to confusion and disappointment, not only for the CNSs themselves, but also the nurse administrators (NAs) in their employment settings. For example, the NAs may believe the educator subrole is the most important function of the CNS, while CNSs may expect to spend the majority of their time in clinical practice. Such disparities in expectations can result in role strain for the CNS and in disillusionment on the part of the NA, with subsequent loss of support for the CNS role. Without the support of the NA, the CNS role may be in jeopardy and, in some cases, will not survive.

Definitions of the CNS Role

American Nurses Association. The role and functions of the CNS have been defined in a variety of ways. The American Nurses Association (ANA) identifies a CNS as a registered nurse who, "through study and supervised clinical practice at the graduate level (master's or doctorate), has become expert in a defined area of knowledge and practice in a

selected clinical area of nursing" (ANA, 1980, p. 23). Role components are defined as clinical practice, education, consultation, research, and administration (ANA, 1986). In discussing the implementation of the role, it was suggested that, depending upon the practice setting, the phenomena of interest to the CNS are what determine the CNS's specialty. "These phenomena may change, reflecting the needs of society, and may therefore cause the boundaries to expand" (ANA, 1986, p. 5). Expansion of practice skills and specialization were the two main characteristics of advanced practice described in the American Nurses Association Social Policy Statement (1980).

The Social Policy Statement (ANA, 1980) is presently undergoing revision, with the new draft retitled *Nursing's Social Policy Statement* (1994). Expanding boundaries in the scope of advanced nursing practice are again discussed. To address the rapidly changing functions in advanced practice, this draft document describes characteristics rather than defining specific roles. Legal regulations are noted to vary from state to state, underscoring the importance of consistent professional definitions and standards of advanced practice.

State nursing associations. State nurses associations have approached the CNS role in a variety of ways. The Oregon Nurses Association's Oregon Council of Clinical Nurse Specialists (OCCNS, 1994) has drafted a position statement regarding CNS practice in which CNSs are defined as "registered nurses with advanced knowledge and competence in a specialty area of the practice of nursing". The Council's statement describes these master's prepared nurses as expert clinicians who provide direct care to individuals, families, and/or communities, in the specialty area for which they have prepared. The OCCNS has submitted their position statement to the Oregon State Board of Nursing, for consideration of its incorporation into Division 50 of the Nurse Practice Act, which addresses the role of nurse practitioners.

The Washington State Nurses Association (WSNA) described no comparable action in support of the CNS role, and, in fact, the state association reports no group representing CNSs within the WSNA. The CNS role in Washington is defined by position descriptions

written by the employing institutions (J. Garner, personal communication, October 6, 1994).

State boards of nursing. The role of the CNS has been of concern to the state boards of nursing as well. The National Council of State Boards of Nursing (NCSBN) adopted a position in 1986 in which the advanced practice nurse (including CNSs, nurse practitioners, nurse anesthetists, and nurse-midwives) required at least a master's degree and expert practice (National Council of State Boards of Nursing, 1987). The NCSBN further defined advanced nursing practice in 1993 to emphasize autonomy, independence, and accountability in complex client care as important components. In the current position statement, the NCSBN collapses all the expanded nurse roles into the single title of advanced practice nurse, and notes that "while there is an overlapping of activities within these roles, there are activities which are unique to each role" (National Council of State Boards of Nursing, 1987, p. 4). Further, a major position shift recommending licensure as the preferred method of regulation of advanced nursing practice is proposed (National Council of State Boards of Nursing, 1993). Since the NCSBN is a recommending body and does not have jurisdiction to make regulations (laws or statutes) governing nursing, it is left to the individual state boards of nursing to initiate and implement legislation regulating CNS nursing practice.

In neither Oregon nor Washington is there specific mention of the CNS in the Nurse Practice Act. Currently, the Oregon state board is considering revisions in the regulation of advanced practice. The position statement prepared by the OCCNS is under consideration as potential changes in the Nurse Practice Act are being formulated. In Washington, the Nurse Practice Act has recently been revised, effective January 1, 1995 . In this revision, a single title of Advanced Registered Nurse Practitioner (ARNP) is used to define all nurse practitioners, nurse midwives, and nurse anesthetists. The only mention of clinical specialists is in psychiatric/mental health nursing; a specialty which, with national certification, may qualify for ARNP licensure. This lack of clarity regarding CNS practice

leaves institutions which hire CNSs to define de facto the limits of their practice (G. Brezarich, personal communication, November 8, 1994).

Summary of definitions. Professional organizations have made significant attempts to define the CNS role. Nursing associations have identified CNS role components and scope of practice, as well as addressed the variety of areas of specialization and rapidly expanding boundaries of the role. State boards of nursing have proposed changes regarding advanced practice in Nurse Practice Acts. Legislative interpretations vary dramatically from state to state, however, and attempts at national standardization are in early stages.

Problem Statement

Although extensive efforts have been made to define the role of the CNS, it remains unclear whether this has significantly impacted NAs' perceptions of the CNS role in Oregon and Washington. The two adjoining states have approached the advanced practice nurse in entirely different ways, with no clarity available for the NA through state Nurse Practice Acts. Health care delivery system changes are rapidly bringing new demands and organizational shifts. In response to these multiple demands, NAs most probably decide the role of the CNS within their institutions on the basis of institutional needs at the time, as well as their own values, experiences in nursing, and other individual factors. On an anecdotal level, CNSs in the Oregon and Washington area report feeling threatened and unsure of how they are perceived or valued.

CHAPTER TWO

Conceptual Framework and Review of the Literature

Role Theory

There are a number of ways of approaching the delineation of advanced practice. Role theory is frequently used in describing the development of the CNS role. Hardy and Conway (1988) explain that role theory is actually a "collection of concepts and a variety of hypothetical formulations that predict how actors will perform in a given role, or under what circumstances certain types of behaviors can be expected" (p. 63). Role theorists view the person in unity with the environment, keeping the individual in a social context. While this value is shared by nursing, some of the language used in role theory is unfamiliar. Topham (1987) suggests that the language of role theory is ambiguous and therefore confusing. For the purposes of this discussion, the definitions provided by Hardy and Conway (1988) will be used to establish a common vocabulary. The terms role occupant, role expectations, role partners, role set, role taking and role making are defined as elements of role development. Role conflict, ambiguity, and incongruity are identified as components of role stress/strain.

Role theory definitions. A role occupant is one who holds the position in question. As used here, the CNS is the occupant, with role expectations, behaviors, and competencies. Role expectations are seen as obligations or demands that are position-specific and that identify the required behaviors for the occupant. Role partners are those who interact with the occupant in a variety of ways. They are in an interdependent position with the occupant and hold expectations for him/her. For the CNS, role partners may include NAs, staff nurses, clients and consumers, physicians, and other health care providers. A role set consists of all the occupant's relationships with the role partners. The collaborative interactions of the CNS with the client, family, and interdisciplinary team members would constitute the role set.

The term role taking is used to identify a process wherein the role is played out/rehearsed or simulated with a wise other and, through role modeling, behavior is altered. An example of this may be when a novice is mentored by an experienced CNS. Role making is the process whereby a new role is structured and/or modified. Hardy and Conway (1988) describe five phases to this process: (1) initiating behavior; (2) response based upon expectations; (3) interpretation by the occupant and a partner; (4) an altered response pattern which is different from previous responses; and (5) validation of the new role if behaviors and responses have been accepted. CNSs are commonly involved in this process of role-making as they implement their advanced practice roles.

A number of terms are used to describe the difficulties encountered in role enactment. Hardy and Conway (1988) discuss role stress, defining it as the objective event which leads to the subjective experience of role strain. The components of role stress include role conflict, role ambiguity, and role incongruence. Role conflict occurs when the occupant perceives others' expectations of the role to be contradictory to or incompatible with his/her own. For example, conflict may arise when NAs' expectations for time spent in research activities exceed those of the CNS. Role ambiguity is defined as occurring when there are disagreements or lack of clarity regarding role expectations. Ambiguity for nurses may be associated with numerous role partners and their varied expectations, as well as the uncertainties about how to implement CNS subroles. Role incongruity occurs when there is a difference between one's educational or experiential preparation and the role expectations. An example of role incongruity for CNSs would be when they are assigned to lead special projects that do not relate to their educational preparation or area of expertise. Factors which contribute to role stress and strain may serve as barriers to the process of role making, and may be an impediment to successful implementation of the CNS role.

Role expectations. Role expectations in relation to the CNS have been extensively explored in the literature. Tarsitano, Brophy, and Snyder (1986) compared the perceptions of the CNS role held by 54 NAs and 35 CNSs of large urban hospitals in Chicago. They

utilized the Clifford Clinical Nurse Specialist Functions Inventory (Clifford, 1981) for determining the values placed on the different CNS role components. The subrole in which the two groups showed a significant difference in value was in the area of research. The NAs judged research to be significantly more important in the CNS role than did the CNSs. These findings are similar to those of Frelin, Oda, and Staggers (1990), in which supervisors rated the research function as being more important than did the CNSs. In this survey of 26 supervisors and 52 CNSs in the Army Medical Department, the supervisors' responses indicated strong support for the CNS role and believed that the position "must be maintained despite budget constraints and nursing shortages" (p.147).

Chambers, Dangel, Germon, Tripodi, and Jaeger (1987) cited the growth of the CNS group, with its variety of applications of the role, as creating confusion about role expectations in hospital personnel. To lessen confusion among hospital staff over role expectations and variations in role implementation, five CNSs developed a generic CNS job description. They suggested the importance of precision in describing CNS functions and flexibility for individual implementation of the role.

Sisson (1987), in a study to identify perceptions of a number of different types of health care personnel, found considerable confusion about various activities that are considered to be a part of the CNS role, even though perceptions were generally positive. A survey was conducted of 120 CNS co-workers to identify expectations of the role from nurse managers, staff nurses, and physicians. The majority of the sample felt the most helpful activities of the CNS were as a staff resource person, and as a staff and patient educator. Most respondents also perceived the CNS to be cost effective. The fact that most of the personnel were unable to identify all of the CNS role functions implies that there may be incongruence with expectations in those who work with CNSs. Sisson concluded that CNSs need to demonstrate their role activities more overtly and educate their co-workers regarding specific activities which are included in the role.

Nuccio et al. (1993) used the Clifford Clinical Nurse Specialist Functions Inventory (CCNSFI) to survey 636 staff nurses on their perceptions of the CNS role. Although there was general agreement among staff nurses that the activities of consultation and education were most important, the authors found varying expectations and accountabilities to be common. They concluded that a list of role expectations may be developed by surveying those who work with CNSs. However, this study did not survey CNSs' perceptions of the relative importance of role functions, for comparison with the staff nurses' perceptions.

Nurse administrators' perceptions of critical care CNSs were studied by Scherer, Jezewski, Janelli, Ackerman, and Ludwig (1994). Nurse administrators from 198 hospitals ranked the relative value of the role components, and concluded that maintaining clinical expertise was of utmost importance. Other role components that were viewed as important were educator, consultant/change agent, researcher and manager, respectively. The ranking of manager as least important supports the findings of the study by Frelin et al. (1990). Support of the NA was identified by McFadden and Miller (1994) as the most crucial factor in CNS role implementation in a survey completed by 288 practicing CNSs across the United States. The respondents identified the role components of patient care/consultation, and education as comprising the majority of their time. The investigators stressed the importance of clarity in role expectations for effective role implementation to occur.

Role stress/strain. The framework of role theory provides a basis for not only understanding the importance of role expectations, but for anticipating the difficulties that arise when these expectations are not met. In discussing how incongruence in role expectations can lead to role strain for the CNS, Tarsitano et al. (1986) cautioned that it could also contribute to "disillusionment on the part of nurse administrators as to the effectiveness of clinical specialists in this component of their role" (p.9). McDougall (1987), in discussing the role of the CNS consultant in organizational development, described role definition as one of the CNS's critical functions. Role conflict and role ambiguity were cited as stress producers which then diminish organizational effectiveness.

Similarly, Montemuro (1987) wrote about the evolution of the CNS, saying that early in its development, the CNS role was expected to be "a panacea that would alleviate all the problems in the nursing profession" (p. 108). While CNSs have become more clear about the role, Montemuro questions how much other health care providers understand what the CNS does. The importance of CNS visibility in decreasing role confusion is emphasized, underscoring this as crucial to the future of the role.

One of the ways that CNSs attempt to clarify their roles is through the use of position descriptions and evaluation tools. Hill, Ellsworth-Wolk and DeBlase (1993) discuss the difficulty in having a single role description, since the role is implemented in such a variety of ways. They say, however, that not capturing the role's contributions has left the CNS role "misunderstood, misinterpreted, and lacking recognition" (p. 267).

Fenton and Brykcznski (1993) compared two of their own previous studies which examined the domains and competencies of nurses in advanced practice roles. Fenton's prior study (1985) consisted of interviews and participant observations of 30 master's prepared CNSs, over a 6 month period, in 242 clinical situations. Brykcynski's former study (1989) utilized interviews and participant observations of 22 nurse practitioners (NPs), over an 8 month period, in 199 situations. When the two studies were compared, Fenton and Brykcznski (1993) found that advanced practice nurses share many domains of competencies, but that one of the three primary areas of difference was in role ambiguity, with role ambiguity being more prevalent in the CNS sample than in the NP sample. The authors speculate that "one reason may be that the CNS's role expectations of expert practitioner, educator, consultant, and researcher as well as change agent have not been as clearly defined and developed in the clinical setting. These expectations are very broad and could be defined quite differently according to the setting or type of institution in which the CNS is employed" (p. 321-322).

Health Care Reform Issues Relative to the CNS Role

Health care organizations, in response to actual or anticipated public need, have been in the process of internal restructuring, which impacts the role of the CNS. Clinical nurse specialists are taking proactive steps in response to these changes by demonstrating cost containment, actively improving quality of care and addressing questions of universal access to care--three issues cited as having utmost importance, in the latest draft of the ANA's Social Policy Statement (American Nurses Association, 1994). In terms of communicating the worth of the CNS role, both cost containment and quality of care are issues of great significance.

Walker (1986) examined NAs' perceptions of the effectiveness of the CNS role, institutions' utilization of the CNS, and factors potentially affecting both. Questionnaires were mailed to 112 private, university, military, Veterans Administration, and U.S. Public Health hospitals, with an average bed size of 342. Of the 82 returns from 81 hospitals, 63% of respondents held the title of Director of Nursing, with Assistant Director, Clinical Director, and Other making up the remaining 37%. Of the 81 hospitals, 57% reported employment of CNSs, with a mean of 4.3 on staff. Interestingly, 95% of respondents reported satisfaction with the CNS role, but only 75% said they would hire a CNS if one was available and a position was open. No explanation was given for this discrepancy, but one might speculate that economic factors influenced this response. A comparable split was noted between the response that CNSs helped improve quality of care (96%) and that they thought the role was cost effective (80%).

McFadden and Miller (1994) described issues of cost containment as having the greatest impact on CNS role implementation. In an article written by an administrator who advocates for CNS use in hospitals, Fralic (1988) described the CNSs' strong clinical presence as clear evidence that the organization and the NA value patient care as the direct work of the organization.

The need to gain administrative support has resulted in the use of various methods for demonstrating the worth of CNSs. Although many NAs consider the CNS to be a valuable asset to an institution, Ferraro-McDuffie, Chan, and Jerome (1993) suggested that this alone may not be adequate for justifying the position. Realizing that one can no longer assume that the mere presence of CNSs improves the quality of patient care, they have developed and implemented a quarterly fiscal report to demonstrate CNSs' financial worth. In times of cost containment and organizational restructuring, many CNSs have implemented such practices of verification to insure future job viability. "Without a clear understanding of the roles of the CNS and their impact on the cost as well as the quality of care, nurse administrators may be reluctant to hire CNSs and/or to support their role during these tough economic times" (p. 96).

In the process of deciding the potential for employing CNSs, NAs must consider the value that the role has in relation to organizational goals. Edwardson (1992) noted the need for health care facilities to balance cost and quality. She proposed a cost-effectiveness analysis when benefits could not be quantified in monetary terms. Many CNS activities may be included here, such as a decrease in apprehension or powerlessness in patients, families, or nursing staff, and increased patient satisfaction, to name a few. She suggested that studies be done which clearly demonstrate CNS cost effectiveness. Nichols (1992) examined this issue from a different perspective, looking at the cost of underutilization of advanced practice nurses, and developed a model to document potential savings. Naylor, Munro, and Brooten (1991) encouraged nurses to document their services and demonstrate their effects on patient outcomes. Hamric (1992) echoed the importance of measuring CNSs' effect on outcomes, saying that the time for discussion is over, and it is now time to "just do it" (p. 14).

Measurement Issues

The literature reveals a large body of work representing CNSs' attempts to document their worth. Numerous authors describe methods for evaluating and recording cost effectiveness (Edwardson, 1992; Ferraro-McDuffie et al., 1993; Naylor et al., 1991; & Nichols, 1992). Others (Brykczynski, 1989; Chambers et al., 1987; Fenton, 1985; & Hill et al., 1993) outlined job descriptions and domains of practice. Articles by Bass, Rabbett, and Siskind (1993), Fralic (1988), Hamric (1992), and Montemuro (1987) addressed the importance of the CNS role, but conducted no research and used no measurement tool.

Research attempts at measuring and comparing perceptions of the CNS role have been limited. McFadden and Miller (1994) used open-ended questions in their exploration of the CNS role. Sisson (1987) utilized a goal-free method of evaluation, with eight open-ended questions regarding how CNS role partners perceive the role. Both of these qualitative methods yield meaningful data, but it becomes difficult to quantify, and even more difficult to make comparisons between groups.

Frelin et al. (1990) adapted a survey instrument previously used by Oda and her associates. This adapted instrument was comprised of demographics and measures of work characteristics, role characteristics, and role perspectives. While work characteristics and role characteristics were measured on a Likert-type scale, role perceptions were addressed using eight open-ended questions, again raising the difficulty of making between-group comparisons, and identifying systematic differences.

A questionnaire was developed by Scherer et al. (1994) which contained 56 items divided into the categories of expert clinician, educator, consultant/ change agent, researcher, and manager. The items were based on review of the literature and the American Association of Critical Care Nurses 1987 position statement on the role definition of the CNS. Nursing directors were asked to indicate which of the functions were part of the CNS role, then to rank order the importance of the five functions. Overall mean scores were then tabulated for the most important (1) to least important (5). The authors' reliability

coefficients for internal consistency for the five categories ranged from 0.71 to 0.95. While the items were very specific to critical care, it is noted that they could be adapted for use in other CNS areas. The authors also recommended that CNSs' perceptions of the role functions be obtained and compared with those of nurse administrators.

Walker (1986) developed a 22-item questionnaire for directors of nursing, exploring both satisfaction and utilization of the CNS. There was no attempt to explore any relationship between how the role was perceived by different groups.

The Clifford Clinical Nurse Specialist Functions Inventory (CCNSFI) is an objective, quantitative instrument used to determine the relative importance of specific functions expected of the CNS in the hospital setting. This 37-item questionnaire uses a Likert-type scale for rating the perception of the importance of each function; content validity was established by expert nurses (Clifford, 1981). It has been used by Clifford to compare perceptions of the CNS role in nurse administrators and nurse educators. Prior to surveying staff nurses' perceptions of the role, Nuccio et al. (1993) distributed the scale to graduate nursing students in order to assess internal consistency reliability. Alpha coefficients for the total scale and each subscale were 0.79 to 0.89. Tarsitano et al. (1986) examined similarities and differences between NAs and CNSs regarding the importance of the four components of the CNS role (clinical practice, education, administration, and research). Radke et al. (1990) used the nine items on the administrative subscale of the CCNSFI for their exploration of administrative preparation of the CNS, and assumed face validity.

In summary, attempts have been made to document the value of the CNS role. Job descriptions, fiscal reports, and time documentation are objective means that have been used in these efforts. Open-ended questions have been used to subjectively explore perceptions of the role. A limited number of studies have utilized objective, quantifiable measures which allow comparison of perceptions of the CNS role between nursing groups.

Conclusion. The role of the CNS has evolved over time and continues to be responsive to changing health care needs. This not only challenges the CNS's ability to

adapt, but may also contribute to conflicting perceptions of the role across time and across employing organizations (Prevost, 1995). Nursing literature is replete with CNS position descriptions and verification tools, but role definition at the individual organizational level remains idiosyncratic to each organization. This partially reflects both the advantage and disadvantage of the flexibility and adaptability of CNS role implementation. It also contributes to the varied role expectations that the CNSs' role partners demonstrate, and in some instances results in role ambiguity or conflict, which constitutes role stress. Since support for the CNS role is contingent upon congruent expectations, it is imperative that NAs and CNSs agree in their perceptions of the role.

Although tools have been used for measuring perceptions held by NAs and CNSs, they most frequently employed open-ended items. This qualitative approach yields meaningful data, but makes comparison across groups difficult. The most frequently used objective, quantitative tool found in the literature that would facilitate comparison between groups is the CCNSFI. While this instrument was developed and tested for content validity in 1981, the author has published no further validity and reliability testing (R. Clifford, personal communication, February 11, 1994). Changes in the health care system and their impact on the evolution of the CNS role may require reevaluation of the tool for currency. Items that explore the concepts of role theory may need to be utilized to augment the CCNSFI. There appears to be a significant need for a comprehensive assessment tool for evaluating role perceptions in a changing health care environment. In spite of its limitations, however, the CCNSFI, augmented with items pertaining to role theory, appears to provide the most useful means currently available for measuring the perceptions of NAs and CNSs.

Purpose

The original intent of this master's research project was to conduct a survey of the perceptions of NAs and CNSs regarding the CNS role. Upon completion of the literature review and a search for measurement tools, it became apparent that any existing instrument

required augmentation in order to also examine the issues within the role theory conceptual framework.

The purpose of this master's research project then shifted to the design and initial pilot testing of a composite instrument to examine perceptions of the CNS role components, activities related to the role making process, and the influence of health care changes on the employment of the CNS in institutional settings. In the initial pilot testing of this instrument, content experts (experienced NAs and CNSs) were selected to establish content validity and offer suggestions regarding clarity of the instrument and feasibility of its administration. In addition, format experts assessed the instrument and provided feedback. This project culminated in a revised version of the composite instrument and a plan for its subsequent pre-testing.

Research Questions

1. To what extent do the items on the CCNSFI accurately represent current CNS role functions as viewed by NAs and CNSs?
2. To what extent do the items on the composite survey instrument pertaining to operationalization of role theory in a changing health care environment accurately represent views of NAs and CNSs?
3. What changes need to be made in the initial draft of the composite instrument in order to incorporate the recommendations of NAs and CNSs and prepare it for future pilot testing?

CHAPTER THREE

Methods

The composite instrument for measuring CNS role perceptions has three major sections. The first section includes demographic data and items related to CNS utilization in a changing health care environment. The second section consists of the CCNSFI, which measures perceptions of relative importance of specific CNS functions. The final section contains items developed by the authors for examining CNS role development within a role theory conceptual framework. New items in the first and third sections are structured in accordance with guidelines for written questionnaires (Dillman, 1978). A copy of the composite instrument is found in Appendix A.

Development of the Tool

Section I (Appendix A, pp. 33-34). The first section of the composite instrument has 16 items. Questions one through seven deal with demographic factors and use multiple choice or fill-in for the response options. The number of CNSs employed three years past, currently, and one year projected in the future is the subject of questions 8 through 10, using a multiple choice format. Question 11 asks for the educational preparation of CNSs, with choices provided, plus an "other" fill-in option. Question 12 seeks information regarding any CNS positions currently unfilled, and is followed by a multiple choice option in question 13 to ascertain reasons for unfilled positions. Question 14 contains multiple categories of changes in health care and queries CNS utilization changes in response to each. The last two questions in this section explore the use of CNSs in staff nurse positions and the use of staff nurses in CNS positions. A Likert-type scale is used for measuring the likelihood of this type of reassignment.

Section II (Appendix A, pp. 35-37). The Clifford Clinical Nurse Specialist Functions Inventory (CCNSFI) was developed in 1981 to identify the most valued CNS

role functions, as perceived by nurse administrators and nurse educators. The inventory items were designed to represent different role functions--clinical, educational, administrative, and research. The items were derived from 107 job descriptions of practicing CNSs, and were reviewed by educators and clinicians. Content validity was established through review by expert educators and clinicians.

According to the author, the original 37 items on the questionnaire are divided as follows: the first 11 items relate to clinical functions, items 12-20 relate to educational functions, items 21-29 relate to administrative functions, and items 30-37 relate to research functions (R. Clifford, personal communication, February 21, 1994). The Likert-type scale of responses are as follows: 0=not expected in the position; 1=slightly important; 2=important; 3=very important; and 4=utmost importance. Permission for the use of the Clifford Clinical Nurse Specialist Functions Inventory was given by Dr. Rita Clifford of the School of Nursing of the University of Kansas Medical Center (Appendix B).

Section III (Appendix A, pp. 38-40). The final section of the composite instrument contains 12 questions relating to aspects of CNS role development. Questions one and two address the CNS job descriptions, based on the assumption that this is an important component of the role making or role taking process. Question three lists a number of methods for clarifying CNS role expectations (using a Likert-type scale to rate each), since unclear expectations may contribute to role stress/strain. The importance of CNS role partners is addressed in questions four and five, using both fill-in and a Likert-type scale. The respondents were asked in question six to rate (in a Likert-type format) the effectiveness of various role partners in the mentoring of novice CNSs. An assumption was made that ineffective mentoring relates to role conflict and role ambiguity. Questions 7 through 10 address the extent of role stress/strain experienced by the CNS, also using a Likert-type scale. The last two questions in this section use a multiple choice format and inquire into the reassignment of CNSs in response to health care changes.

Sample

Format experts. A newly developed instrument requires that a number of steps be taken for pilot testing (Waltz, Strickland, & Lenz, 1991). One of the first steps is assessing the instrument's feasibility for administration and scoring. For this purpose, experts known to the authors were utilized. Two of the three format experts for this project were master's prepared staff members in the Office of Research Design and Utilization in the School of Nursing of the Oregon Health Sciences University. The third was a doctorally prepared research psychologist, practicing in the community. They examined the composite tool for readability, design, and logical flow. Their suggestions were used in conjunction with those of the content experts in the revision of the instrument.

Content experts. A minimum of three experts is recommended for content validation, since this allows for a decision for change to be based on two-thirds majority (V. Tilden, personal communication, February 15, 1995). Three practicing, master's prepared CNSs known to the investigators were chosen, and paired with their immediate nurse administrator. These pairs were selected because they were experienced with the CNS role and represented a variety of employment settings (ambulatory care, acute care, and long-term care) and specialties (medical-surgical nursing and geriatric nursing).

Procedure for Pilot Testing

Human subjects review. Application to the Committee on Human Research at Oregon Health Sciences University was required prior to implementation of the composite instrument. Since this study involved interview and survey procedures in which subjects cannot be identified, it fell under category #2 of the federal regulations (45 CFR Part 46.101 (b)), and was exempt from review by the Committee on Human Research (Appendix C).

Recruitment of participants. Initially, the CNSs were contacted either in person or by telephone, and each of them ascertained their NA's willingness to participate. Follow-up telephone contact was used to establish interview appointments.

One of the two investigators scheduled meetings with the three CNSs; the other investigator met with the three NAs. The appointments were made during the content experts' regular workday schedules at their places of employment. To allow ample time to both complete the questionnaire and to obtain feedback on the items, one and one-half hours was requested for each appointment. Rescheduling was necessary with one CNS due to illness, and one NA due to unforeseen work demands.

Testing the composite instrument. In order for the six sessions with the content experts to be as consistent as possible, a structured interview schedule was prepared in advance (Appendix D). It was used for introducing the project, establishing guidelines for the experts' participation, and reviewing the questionnaire after its completion.

The scheduled one and one-half hour sessions had been requested as a block of time in a quiet setting, away from distractions, in order for the participants to give full attention to the process. After the introduction was read by the investigator, the participant was requested to complete the questionnaire in its entirety, so that the time required for administration could be noted. Following completion of the questionnaire, interviews were conducted using the interview schedule, with written notes taken by the investigators. After each session the completed questionnaire, the investigator's written notes of the participant's responses to the structured interview, and noted time requirements for both the questionnaire and entire session were retained by the investigators for future analysis.

Summary of Findings

The initial pilot testing of this composite instrument consisted of assessment of each of the 65 items by both content and format experts. Their responses on the interview questions were the primary mechanism for determining whether an item needed to be changed or eliminated. A two-thirds majority opinion was used as a guideline for disposition of each item. The three possibilities were either to keep each one as is, revise an item, or drop an item completely.

The use of only six participants was appropriate for the intent of this project, which was to complete the first assessment of content validity for the composite instrument. This number lacks representativeness, however, in examining the results of the data gathered by the composite instrument. Although the small sample size yielded limited statistical data, frequencies, means, and modes were computed when appropriate, and the results were analyzed for general impressions.

Products of Masters Research Project

It was agreed by the authors' Master's Research Project committee that the final product of this project to develop an instrument for surveying perceptions of the CNS role would be a written report that included the following:

1. The Master's Research Project Proposal;
2. A summary of questionnaire responses (Appendix E);
3. A revised composite instrument (Appendix G);
4. A plan for the next step in pilot testing of the instrument;
5. Correspondence with Dr. Rita Clifford regarding findings (Appendix H).

CHAPTER FOUR

Results and Discussion

Results

The primary purpose of this project was to develop an instrument for measuring perceptions of the CNS role. While the CCNSFI has been validated for this purpose, its origination in 1981 gave rise to concerns regarding its currency. An augmented and/or revised instrument was indicated, with particular interest in: (1) addition of items in relation to current health care changes; (2) items that reflect a role theory framework; and (3) determining the current validity of the items on the CCNSFI. In preparation for future pilot testing, the initial draft of the composite instrument was assessed by both format and content experts, and their recommendations, as noted by the investigators on the interview schedules, were summarized to facilitate analysis.

Interview responses of section I (Appendix E, pp. 46-47). The variety of settings in which CNSs are found has broadened, so that using "hospitals" as the only response choice in gathering this data is too limited Other health care organizations, such as long-term care facilities and ambulatory care settings, were seen as necessary choice options, and were added. Similarly, the assignment of CNSs in a variety of settings makes the question of numbers of hospital beds irrelevant, so this item was deleted.

Three of the six content experts were unsure of the employment patterns of CNSs in their organization, and one requested that a "Don't know" option in questions 8 through 10 be made available. Formatting experts recommended the addition of the word "Approximately" as preferable to giving a "Don't know" response option.

Changes in health care (question 14) were rated by the majority of respondents as causing no change in CNS utilization. However, none of the experts judged this to be an inappropriate item in their evaluation of content validity. It was decided that "No change" responses to the item were meaningful data, but insufficient cause for removing the item.

When asked of any experience with reassignment of CNSs to staff nurse positions or staff nurses to CNS positions (questions 15 and 16), two of the respondents stated that it could be interpreted as temporary coverage of duties. Wording was changed to clarify the intent of permanent reassignment of duties.

Interview responses of section II (Appendix E, pp. 48-51). One of the two areas of the CCNSFI that was questioned by the experts related to the role of the CNS in educational functions. The CNSs' contributions in educational functions were noted to be more leadership-oriented than the items indicated. In questions 16 and 17, the words "participates in" (in reference to inservice education) were changed to "contributes to". The second suggested change was of an item referring to the nursing research process (question 34). This item was seen as unclear, so was restated more clearly as "applied nursing research in the clinical setting."

None of the items on the CCNSFI were consensually judged as inappropriate, nor were there areas that were identified as needing additional coverage.

Interview responses of section III (Appendix E, pp. 52-54). Question two, regarding components of job descriptions, asked about "directing the CNS to perform." In the view of one expert, the terminology was too authoritarian, since the CNSs are professionals, and may even write their own job descriptions. In response to this input, the wording was changed in the revised tool, since using nonthreatening terms in questionnaires is recommended (Dillman, 1978).

The transition statement on page six, which was designed to orient repondents to role theory terms, led one expert to believe that her responses were limited to the examples given. To avoid confusion, the statement was revised to clarify that the role partners listed were not all-inclusive.

The rating of the effectiveness of mentoring novice CNSs in question six raised interesting questions regarding role making, since NAs rated their own effectiveness considerably higher than did the CNSs. An item was added to inquire about the perceived

importance of mentoring, which would allow for comparisons between perceived effectiveness and perceived importance of mentoring of the CNS.

Although one respondent expressed the opinion that "role strain" for the CNS was overemphasized (questions 7 through 10), it was decided by the researchers that this was insufficient cause for removal of any of the items.

Questions 11 and 12, regarding reassignment of CNSs within the past two years, or anticipated reassignment in the next two years caused considerable confusion. A number of respondents complained of the lack of clarity and nonapplicability. The format has been changed to open-ended questions, allowing the respondents to identify and discuss issues of CNS role changes in their organization.

General interview questions (Appendix E, pp. 54-55). The time for completion was deemed reasonable by all respondents. The time required ranged from 20 minutes to 44 minutes, with a mean of 26 minutes. The range of the total interview time was 30 to 110 minutes. The print size was not a problem for anyone. The final question was: "How do you think the results of this survey might best be used?" The majority of respondents indicated that it would be valuable to compare their organization's use of the CNS with that of others.

Questionnaire data. Completion of the composite instrument by the six experts was necessary to perform the initial steps of piloting. The data gathered from the responses on the questionnaires were summarized, and statistical data, such as frequencies, means, and modes were computed when indicated. This provided some early impressions, which have been incorporated into the discussion of the results.

Discussion

The data gathered as a necessary part of piloting of the instrument presented some interesting preliminary impressions, even though the sample size is small and lacks representativeness. A discussion of these impressions is below.

Data summary, section I (Appendix F, pp. 56-58). The demographic data indicated a slight projected rise in the number of CNSs employed in these institutions, but did not indicate any significant change in CNS utilization. The data showed positive support for this advanced practice role because, according to this group of experts, staff nurses were not expected to replace master's-prepared CNSs.

Data summary, section II (Appendix F, pp. 59-67). In the part of the CCNSFI that represents clinical functions (questions 1 through 11), the NAs and CNSs had similar frequency distributions, means, and modes on most of the items. The exception was question five, which addresses administration of routine, direct patient care. The NAs had a mean of 0.67 and a mode of 1, while the CNSs had a mean of 2.33 and a mode of 2. One explanation of the difference might be due to the NAs' belief that these highly skilled nurses would not be efficiently used in routine patient care. Also, the meaning of the term "routine patient care" may be viewed differently by the respondents.

Questions 12 through 20, which represent educational functions, showed no dramatic differences between the two groups. It was interesting to note, however, that both groups rated the importance of participation in formal and informal inservice education for non-nurse health care personnel as fairly low (NAs' mean=1.33; CNSs' mean=1.00). Conversely, the role of consultant to the nursing staff was seen by both groups as very important, with the NAs' mean being 4.00, and CNSs' being 3.67.

Similarly, in the administration function section, the groups were fairly comparable in their frequency distribution. They were in agreement that CNS participation in decisions regarding employment and termination of nursing personnel was a low priority. For both these items, the mean for NAs was 0.67, and for CNSs, it was 1.67. Maintaining a system of peer review was also rated low by both groups, with the NAs' mean being 1.67, and CNSs' mean being 0.33.

All the research items showed congruence between the NAs and the CNSs, and the seven items were all highly rated, with the lowest mean being 2.33. Certainly, this indicates that both groups endorsed research functions as important for the CNS role.

Data summary, section III (Appendix F, pp. 68-71). Although there was considerable variation in responses to questions regarding whether the CNS job description was specific or generic, most experts endorsed the traditional CNS subroles as being components of their job description. This endorsement should indicate clarity in role expectations between a CNS and NA, which would assist in the role taking process. However, one respondent noted that the CNSs write their own job descriptions, which addresses the role making process. That process describes the need for feedback in developing a new position. Interestingly, when questioned regarding the effectiveness of methods in clarifying expectations of the role, CNSs rated informal feedback from NAs as more important than did the NAs. Another item exploring role development requested that the respondents rate the effectiveness by various nurses in mentoring novice CNSs. Nurse administrators rated their own effectiveness considerably higher than did the CNSs. It became clear that it would be interesting to compare perceived effectiveness of mentoring with perceived importance of mentoring, so an item was added for this purpose.

In discussing the importance of CNS role partners, all three NAs identified the primary role partner as the senior NA, but the CNSs varied in their responses. Each of the three CNSs chose a different top-most role partner: "other nurses", "nursing directors", and "department managers". A similar discrepancy was noted in the responses regarding how effectively the CNSs located and established relationships with their priority role partners. Here again, the NAs rated this higher than did the CNSs. In role theory terms, the lack of congruence in the perceptions of the NAs and the CNSs would predict role stress/strain. Unexpectedly, while the NAs generally rated the CNSs' role development as progressing better than did the CNSs, it was the NAs who endorsed a perception of a higher level of role stress/strain for the CNSs.

Research Questions. Research question number one asked "To what extent do the items on the CCNSFI accurately represent current CNS role functions as viewed by NAs and CNSs?" There were no items on the CCNSFI that were consensually agreed upon by the content experts as failing to represent current CNS role functions. Although minor revisions in wording were made for three items, there were no major changes recommended by the experts.

The second research question inquired into the extent that the items on the composite survey instrument pertaining to operationalization of role theory in a changing health care environment accurately represent views of NAs and CNSs. An assumption was made, when designing the questionnaire, that effective mentoring, CNS job descriptions, and sufficiently establishing relationships with primary role partners may represent operationalization of role theory, but these issues would seem to need reliability testing (a study in and of itself) to ascertain if this is so. Since the response to these items was positive, there is some indication that the previous assumption may be true. This research question needs further examination.

The final research question has been answered in the responses to the interviews (in the "Results" section of this chapter). It asked: "What changes need to be made in the initial draft of the composite instrument in order to incorporate the recommendations of NAs and CNSs and prepare it for future pilot testing?" The suggestions from the experts who participated in this project were the basis for the revisions in the composite instrument (Appendix G). In establishing content validity for the tool, the purpose of the project was met.

Conclusion. In preparing to conduct a survey of the perceptions of NAs and CNSs regarding the CNS role, it became apparent that any existing instrument required augmentation or revision in order to examine the issues within a role theory conceptual framework. This project focused on developing items to augment the CCNSFI, and validating the content of the composite instrument. The initial steps of piloting have not

only established content validity, but have also provided a suggestion of the potential array of data that could be obtained.

In considering the composite instrument in its entirety, the potential information derived from a full study would be rich in the areas of changes in health care, CNS role functions, and role development. This small pilot certainly raises questions for further study.

Plan for next phase. According to Waltz, Strickland, and Lenz (1991), the second pilot-testing activity is to pretest the instrument, using subjects as similar to the intended target population as possible. If this advice is followed as suggested (pretesting 20 to 30 people), the local sample available for study would be largely utilized. Given this, further research to establish validity and reliability could be conducted simultaneously with an actual survey.

A study of perceptions of the CNS role, using the composite tool with NAs and CNSs from health care facilities in the metropolitan areas of Portland, Oregon and Seattle, Washington could yield data for both psychometric testing and survey results. There are approximately 10 hospitals with more than 100 beds in each area. (The size of the organization is relevant, since the more complex case loads in large facilities are more likely to generate a requirement for a CNS). Mailed questionnaires would be sent to CNSs and their senior NAs at each of the health care facilities employing CNSs. Demographic and institutional data would be used for putting the survey data in context. These data could be analyzed using descriptive statistics, specifically: frequencies, percentages, and means.

Survey research is frequently used in social science research, to determine what exists and how it exists, in groups. Polit and Hungler (1993) give the following purposes for survey research: description, explanation, prediction, and exploration. Clifford (1981) states that the CCNSFI yields descriptive, explanatory, and exploratory information, but lacks predictive ability. The items added to the composite instrument may provide predictive elements, based on knowledge of the role development process.

Section two of the composite instrument (the CCNSFI), and some of the added items in sections one and three, may be treated as interval scale measures. This offers the capability (in addition to frequencies, percentages, and means) of performing a t-test for independent measures, to determine if any differences in CNSs' and NAs' perceptions of the CNS role are statistically significant.

Concurrent piloting of the instrument could be done, since the survey subjects would also be content experts, and could provide input regarding validity. A participant feedback mechanism similar to the one described in this project could be implemented. Reliability could also be assessed using split-half reliability testing or Cronbach's alpha.

The suggested revisions that were provided by both the format experts and the content experts during the first stage of piloting have been incorporated into the revised composite instrument. Feedback regarding the CCNSFI in this site has been reported to the original researcher (Appendix H). The tool is now ready for a study to be implemented.

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CLINICAL NURSE SPECIALIST QUESTIONNAIRE

Section I. THE QUESTIONS IN THIS SECTION ARE TO HELP US TO UNDERSTAND SOMETHING ABOUT YOUR ORGANIZATION, AND HOW THE CURRENT HEALTH CARE ENVIRONMENT MAY BE IMPACTING IT IN RELATIONSHIP TO THE USE OF THE CLINICAL NURSE SPECIALISTS (CNSs).

Q-1. Please indicate the type of institution with which you are affiliated.

1. UNIVERSITY HOSPITAL
2. PRIVATE COMMUNITY HOSPITAL
3. PUBLIC COMMUNITY HOSPITAL
4. FEDERAL GOV'T (MILITARY, VA)
5. OTHER_____

Q-2. How many beds in your institution?

1. 200 OR LESS
2. 201-400
3. 401-600
4. MORE THAN 600

Q-3. What is your current title?

_____

Q-4. How long have you held this title?

1. LESS THAN ONE YEAR
2. BETWEEN ONE AND THREE YEARS
3. THREE TO FIVE YEARS
4. MORE THAN FIVE YEARS

Q-5. What is the title of the person to whom you report?

_____

_____

Q-6. How would you characterize your position in the organization?

1. TOP-LEVEL NURSE ADMINISTRATOR
2. MID-LEVEL NURSE ADMINISTRATOR
3. CNS
4. OTHER_____

Q-7. What is the highest educational degree you hold?

1. ASSOCIATE DEGREE
2. DIPLOMA
3. BACCALAUREATE IN NURSING
4. BACCALAUREATE IN OTHER FIELD
5. MASTER'S IN NURSING
6. MASTER'S IN OTHER FIELD
7. DOCTORATE IN NURSING
8. DOCTORATE IN OTHER FIELD

Q-8. How many CNSs were employed in your institution three years ago?

1. NONE
2. ONE
3. TWO
4. THREE
5. FOUR
6. IF MORE THAN FOUR *(number)*_____

Q-9. How many CNSs are currently employed in your institution?

1. NONE
2. ONE
3. TWO
4. THREE
5. FOUR
6. IF MORE THAN FOUR *(number)*_____

Q-10. What do you project the number of CNS positions to be one year from now?

1. NONE
2. ONE
3. TWO
4. THREE
5. FOUR
6. IF MORE THAN FOUR *(number)*_____

Q-11. How many CNSs in your institution are: MASTER'S PREPARED____DOCTORALLY PREPARED___

OTHER_____*(if other, please describe)*_____

Q-12. Do you have any CNS positions currently unfilled in your institution?

1. NO (go to Q-14.)
2. YES (go to Q-13.)

Q-13. If CNS positions are not filled, what do you see as the reason(s)?

1. POSITION NOT BUDGETED
2. LACK OF APPLICANTS
3. QUALIFIED PERSON NOT AVAILABLE
4. REASON UNKNOWN
5. OTHER *(please elaborate)*_____

Q-14. Have any of the following changes in health care resulted in changes in CNS utilization in your organization? *(Circle all that apply)*

CHANGES IN HEALTH CARE:	CNS UTILIZATION CHANGE:				
	No change	Let CNSs go	Hired more CNSs	Reassigned CNSs	Other *(elaborate below)*
1. CAPITATED CARE	1	2	3	4	5
2. DECREASED LENGTH OF STAY	1	2	3	4	5
3. INCREASED PATIENT ACUITY	1	2	3	4	5
4. INCREASED USE OF UNLICENSED ASSISTIVE PERSONNEL	1	2	3	4	5
5. ISSUES OF "TURF" BETWEEN PHYSICIANS AND NURSES	1	2	3	4	5
6. CHANGE IN PHILOSOPHY ABOUT TYPE OF ADVANCED PRACTICE NURSE NEEDED	1	2	3	4	5
7. OTHER *(please elaborate)*					

_____

*(comments)*_____

Q-15. To what extent has your organization considered reassigning an experienced CNS to a staff nurse position?

Not at all				Great deal
1	2	3	4	5

Q-16. To what extent has your organization considered asking experienced non-master's prepared nurses to perform the functions of a CNS?

Not at all				Great deal
1	2	3	4	5

Section II. THIS SECTION UTILIZES THE CLIFFORD CLINICAL NURSE SPECIALIST FUNCTIONS INVENTORY (WITH AUTHOR'S PERMISSION), AND FOCUSES ON THE IMPORTANCE OF SPECIFIC FUNCTIONS OF THE CNS.

Please circle the number which indicates your perception of the importance of each function in the job of the CNS.

	Not expected the position	Slightly important	Important	Very important	Utmost importance
Q-1. Assesses patient problems.	0	1	2	3	4
Q-2. Establishes a nursing diagnosis.	0	1	2	3	4
Q-3. Establishes long and short term goals for care of individual patients.	0	1	2	3	4
Q-4. Prescribes nursing interventions.	0	1	2	3	4
Q-5. Administers routine direct patient care.	0	1	2	3	4
Q-6. Administers specialized direct patient care.	0	1	2	3	4
Q-7. Initiates health teaching to be done by other nursing personnel for patients and families based on nursing assessment.	0	1	2	3	4
Q-8. Implements health teaching for patients and famililes based on nursing assessment.	0	1	2	3	4
Q-9. Assesses quality of nursing care in specific area.	0	1	2	3	4
Q-10. Promotes upgrading of nursing care in specific area.	0	1	2	3	4
Q-11. Coordinates patient care with other disciplines or departments.	0	1	2	3	4
Q-12. Develops assessment and evaluation tools to assist staff in planning and providing care.	0	1	2	3	4
Q-13. Acts as consultant for nursing staff.	0	1	2	3	4

	Not expected in the position	Slightly important	Important	Very important	Utmost importance
Q-14. Acts as consultant for medical staff.	0	1	2	3	4
Q-15. Provides assistance to nursing staff in meeting identified patient and family health education needs.	0	1	2	3	4
Q-16. Participates in formal and informal inservice education for non-nursing health personnel.	0	1	2	3	4
Q-17. Particpates in formal and informal inservice education for nursing personnel.	0	1	2	3	4
Q-18. Serves as a role model for nursing students.	0	1	2	3	4
Q-19. Assists with clinical and theoretical teaching of nursing students.	0	1	2	3	4
Q-20. Contributes to the education of the public through participation in health oriented organization programs and/or membership activities.	0	1	2	3	4
Q-21. Participates in institutional committees which influence or determine policies affecting nursing practice.	0	1	2	3	4
Q-22. Takes leadership in defining, maintaining, and interpreting standards of nursing practice.	0	1	2	3	4
Q-23. Participates in formal evaluation of nursing personnel.	0	1	2	3	4
Q-24. Has responsibility for all nursing activities in a clinical area.	0	1	2	3	4

	Not expected in the position	Slightly important	Important	Very important	Utmost importance
Q-25. Participates in decisions regarding employment of nursing personnel.	0	1	2	3	4
Q-26. Participates in decisions regarding termination of nursing personnel.	0	1	2	3	4
Q-27. Takes leadership in the development and maintenance of a system of peer review for nursing personnel.	0	1	2	3	4
Q-28. Participates in evaluating conditions, resources, and policies essential to the delivery of nursing care services.	0	1	2	3	4
Q-29. Monitors changing needs of clinical area and institutes appropriate change.	0	1	2	3	4
Q-30. Assesses the needs for nursing research in clinical area.	0	1	2	3	4
Q-31. Identifies relevant clinical questions appropriate for systematic study.	0	1	2	3	4
Q-32. Plans nursing studies according to accepted nursing research standards.	0	1	2	3	4
Q-33. Conducts research relating to nursing practice.	0	1	2	3	4
Q-34. Evaluates the nursing research process.	0	1	2	3	4
Q-35. Interprets to nursing personnel the results of nursing research.	0	1	2	3	4
Q-36. Assists nursing personnel in utilizing research to effect change.	0	1	2	3	4
Q-37. Communicates results of research through presentations and publications.	0	1	2	3	4

Section III. THIS SECTION RELATES TO ASPECTS OF CNS ROLE DEVELOPMENT.

Q-1. In your organization, is the CNS position description.....

1. SPECIFIC FOR EACH CNS
2. GENERIC FOR ALL CNSs
3. OTHER *(Please descibe)*_____

Q-2. Does the job description contain language directing the CNS to perform: *(Circle yes or no for each)*

1. DIRECT PATIENT CARE.....Yes.....No
2. INDIRECT PATIENT CARE.....Yes.....No
3. STAFF TEACHING.....Yes.....No
4. PATIENT TEACHING.....Yes.....No
5. RESEARCH.....Yes.....No
6. CONSULTATION.....Yes.....No
7. COLLABORATION.....Yes.....No

Q-3. Please rate the effectiveness of each of the following methods in clarifying expectations of the CNS role:

EFFECTIVENESS

Lowest Highest

1. POSITION DESCRIPTIONS.....1.....2.....3.....4.....5.....6.....7
2. CNS QUARTERLY CONFERENCES WITH IMMEDIATE SUPERVISORS....1.....2.....3.....4.....5.....6.....7
3. REVIEW OF SELF EVALUATION WITH SUPERVISOR.....1.....2.....3.....4.....5.....6.....7
4. PEER REVIEW.....1.....2.....3.....4.....5.....6.....7
5. INFORMAL FEEDBACK FROM NURSE ADMINISTRATOR.....1.....2.....3.....4.....5.....6.....7
6. INFORMAL FEEDBACK FROM OTHER NURSE COLLEAGUES.....1.....2.....3.....4.....5.....6.....7
7. OTHER_____...1.....2.....3.....4.....5.....6.....7

According to role theory, role partners are those who interact with the role occupant in a variety of ways, in order to meet the expectations of the role. For the CNS, role partners may include nurse administrators, CNSs and other nurses, clients and families, physicians, and other health care providers.

Q-4. Who, in your estimation, are the top three role partners in your organization with whom a CNS must establish and maintain a relationship?

_____

_____

_____

Q-5. In your opinion, how effectively have the CNSs in your organization located and begun to establish relationships with the priority role partners for their practice in the first year of employment?

Lowest						Highest
1	2	3	4	5	6	7

Q-6. Mentoring of novice CNSs may be done by a number of different people. For your organization, how would you rate the effectiveness of each of the following people in mentoring novice CNSs?

	Lowest					Highest
1. NURSE ADMINISTRATORS	1	2	3	4	5	6	7
2. OTHER CNSs	1	2	3	4	5	6	7
3. SELECTED STAFF NURSES	1	2	3	4	5	6	7
4. NURSE MANAGERS	1	2	3	4	5	6	7
5. OTHER_____	1	2	3	4	5	6	7

According to role theory, role stress and strain result when expectations are contradictory or incompatible, (role conflict), when there is lack of clarity (role ambiguity), and when there is a difference between preparation for the role and the expectations of the role (role incongruity).

Q-7. To what extent do you think CNSs in your organization experience role stress/strain?

Lowest						Highest
1	2	3	4	5	6	7

Q-8. To what extent would you estimate role stress/strain to be a factor in CNS difficulties with job performance?

Lowest						Highest
1	2	3	4	5	6	7

Q-9. To what extent would you estimate role stress/strain as the major cause of resignations by CNSs in your organization?

Lowest						Highest
1	2	3	4	5	6	7

Q-10. To what extent would you estimate that terminations of CNSs in your organization have been related to unresolved issues of role stress/strain?

Lowest						Highest
1	2	3	4	5	6	7

Q-11. During the past two years, have any of the following happened to CNSs in your organization?
(Circle all that apply)

1. REASSIGNMENT TO AN EXPANDED POSITION
2. ASSIGNMENT TO DEVELOP A NEW PRODUCT LINE OR SERVICE FOR YOUR HOSPITAL/UNIT
3. REASSIGNMENT TO A LINE OR ADMINISTRATIVE POSITION
4. REASSIGNMENT TO ANOTHER SERVICE.....
   A. Within nursing service
   B. External to nursing service
5. OTHER (please explain)_____

_____

Q-12. Do you envision any of these changes happening to CNSs in your organization in the next two years?
(Circle all that apply)

1. REASSIGNMENT TO AN EXPANDED POSITION
2. ASSIGNMENT TO DEVELOP A NEW PRODUCT LINE OR SERVICE FOR YOUR HOSPITAL/UNIT
3. REASSIGNMENT TO A LINE OR ADMINISTRATIVE POSITION
4. REASSIGNMENT TO ANOTHER SERVICE
   A. Within nursing service
   B. External to nursing service
5. OTHER (please explain)_____

_____

The University of Kansas Medical Center

Student Affairs
School of Nursing
1030 Taylor Building

February 21, 1994

Ramona Lewis
14527 SW Grayling Lane
Beaverton, OR 9700?

Dear Ramona:

Thank you for your inquiry about the Clifford Clinical Nurse Specialist Functions Inventory. You certainly have my permission to use it in your study. I enclose a copy for your convenience. There is no cost associated with it. There are two limitations of which I am aware. First of all, no reliability information has been developed, and secondly, no factor analysis has been done to determine if the items really fall in the categories which I intended. These are both things I intended to complete. However, I have not done so. I developed it with the idea that items 1-11 related to clinical functions, items 12-20 related to educational functions, items 21-29 related to administrative functions, and items 30-37 related to research functions. Of course you will need to modify the instructions to make them appropriate to your sample.

I have copied the pages from my dissertation which relate to the development of the instrument. Perhaps this will be helpful to you.

Best wishes to you for success with your project! If I can be of any further help, please let me know. I would be interested in any results if you decide to use the instrument.

Sincerely,

Rita Clifford, R.N., Ph.D.
Associate Dean
School of Nursing

RC:esd

Appendix C

OREGON
HEALTH SCIENCES UNIVERSITY
3181 S.W. Sam Jackson Park Road, Portland, OR 97201-3098
Mail Code L106, (503) 494-7887 Fax (503) 494-7787
Institutional Review Board/Committee on Human Research

DATE: April 19, 1995

TO: Ramona C. Lewis, MS SN-AHI

FROM: Heidi Moore, Administrative Assistant HMoore
Committee on Human Research, OHSU L-106

RE: Project Title: Instrument Development for Measuring Perceptions of the Role of the Clinical Nurse Specialist.

This confirms receipt of the above mentioned research study proposal. It is my understanding that this study involves interview or survey procedures that will be recorded in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. It therefore falls under category #2 of the federal regulations (45 CFR Part 46.101 (b)) and is considered to be exempt from review by the Committee on Human Research.

This study has been put into our exempt files, and you will receive no further communication from the Committee concerning this study. However, if the involvement of human subjects in this study changes, you must contact the Committee on Human Research to find out whether or not those changes should be reviewed. If possible, please notify the Committee when this project has been completed.

Thank you for your cooperation.

Script for Interview

Each of the participants had arranged a one and one-half hour block of time in a quiet setting, away from distractions, in order to give full attention to the process. All necessary questionnaires and writing materials were made available to the participants. The beginning and ending times for completing questionnaires and interviews were noted for each participant. The structured interview questions were formatted with space available for written notation of the participants' verbal responses by the investigators.

Introduction. "We appreciate your willingness to participate in this project. When we began, we wanted to survey NAs' and CNS' perceptions of the CNS role and compare them. We thought there might be differences here in the northwest region and we could find nothing in the literature about this area.

We found that the instruments available were fairly limited, so our project became development of a survey instrument to look at CNS role perceptions, using a role theory framework. One part of the initial steps in developing a new instrument is, of course, getting feedback from experts like you in the content area. This valuable feedback will be utilized in the revision of the instrument and refining for further piloting.

Initially, we would like for you to respond to the survey items from the mind-set of the (NA/CNS), simulating the intended use of the instrument as much as possible. In order to also obtain information about the time required to take the test, we would like for you to proceed through the three sections. There is room for notations (stars, etc.) to use as reminders, so that when we review your impressions of the survey--section by section--you will be able to give input regarding revisions that should be made. In the discussion afterward, I have specific questions but also will be asking for your general impressions. Right now, I'll ask you to complete the questionnaire."

When the participant had completed the entire questionnaire, the investigators reviewed the composite instrument, section by section.

"In section one, we covered questions relating to demographics and CNS utilization."

Section I

1. **Do any of the closed-ended questions need different choice options than the ones available?**
2. **Is this section readable with logical flow?**
3. **Does any part of this section suggest bias?**
4. **Are there any items in this section that you see as unnecessary?**
5. **Are there items you would recommend to be added?**
6. **Is there something important we haven't covered?**

Section II

"This section of the composite instrument was developed by Dr. Rita Clifford in 1981. Now, in 1995, we want to make sure that it is still a relevant tool."

1. **Are there any items that you think are unnecessary?**
2. **Are there items that you think need to be added?**
3. **The author intended the first 11 items to relate to clinical functions of the CNS. When you look at those 11 items, are there any there that do not relate to clinical functions? Should any be added?**
4. **Numbers 12-20 relate to educational functions. Are there any that don't belong? Any that should be added?**
5. **Questions 21-29 relate to administrative functions. Are there any that don't belong? Any that should be added?**
6. **Questions 30-37 relate to research functions. Are there any that don't belong? Any that should be added?**

"Now, in section three, we included questions based on role theory."

Section III

1. **Do any of the closed-ended questions need different choice options than the ones available?**
2. **Is this section readable with logical flow?**
3. **Does any part of this section suggest bias?**
4. **Are there any items in this section that you see as unnecessary?**
5. **Are there items you would recommend to be added?**
6. **Is there something important that we haven't covered?**

"Now, just a few questions about the composite instrument overall."

General Interview Questions

1. **Do you think the time it took to complete the questionnaire is reasonable?**
2. **Was the print size adequate for ease in reading?**
3. **How do you think the results of this survey might best be used?**

"Thank you very much for your time and attention to this project."

Summary of Responses (Interview Schedule)

Section I

1. **Do any of the closed-ended questions need different choice options than the ones available?**

   CNS #1: Ambulatory care and out-patient settings should also be an option in question 1. Certification should also be addressed, and length of certification.

   CNS #2: Referring to question 4: Need to be more specific about how long in present role compared to how long as a CNS or NA.

   CNS #3: In question 1, long-term care facilities should also be an option.

   NA #1: Add "Don't know" to questions 12,14, 15, and 16.

   NA #2: They're pretty much OK.

   NA #3: Number one didn't include long-term care option, so "other" was used. Question 14 did not apply so much to long-term care.

2. **Is this section readable with logical flow?**

   CNS #1: Yes, very nice.

   CNS #2: Yes.

   CNS #3: I had no trouble at all with it.

   NA #1: It was OK.

   NA #2: Yes, it seemed OK.

   NA #3: It was OK.

3. **Does any part of this section suggest bias?**

   CNS #1: No

   CNS #2: In question 14 (4), it implies that there is a relationship between unlicensed personnel and CNSs; this is not so in our system. In question 14 (5), it implies that turf issues exist, and they do not here.

   CNS #3: No, no bias at all.

NA #1: No.

NA #2: No.

NA #3: No.

4. Are there any items in this section that you see as unnecessary?

CNS #1: On question 13, "Position not budgeted" means it's not there.

CNS #2: Question 14, numbers 4 and 5 don't need to be there.

CNS #3: No.

NA #1: No.

NA #2: No.

NA #3: No.

5. Are there items you would recommend to be added?

CNS #1: "Budget constraints" should be added to question 14.

CNS #2: Add something about CNSs as case managers.

CNS #3: No.

NA #1: No.

NA #2: No.

NA #3: No.

6. Is there something important we haven't covered?

CNS #1: Certification. Also CNS/NP as a dual role.

CNS #2: Case management. Managed care.

CNS #3: No.

NA #1: No.

NA #2: Patient re-design. The CNS role as teacher may change, with increased use of unlicensed personnel. The CNS is functioning more as a case manager.

NA #3: No.

Section II

"This part of the composite instrument was developed by Dr. Rita Clifford 1981. Now, in 1995, we want to make sure that it is still a relevant tool."

1. **Are there any items that you think are unnecessary?**

   CNS #1: My perceptions are different than "not expected in the position."

   CNS #2: The first six questions and #8 are not unique to the CNS role. Every nurse does those things. Question #7 is unnecessary because, as a CNS, I'm not going to initiate any teaching that's going to be done by the nurses. That's unrealistic.

   CNS #3: No.

   NA #1: No, it (CNS) is still a catch-all kind of job. Certain aspects of staff development, but that's not the role of the CNS.

   NA #2: No, the range is good. We're in a different setting here (out-patient).

   NA #3: No.

2. **Are there items that you think need to be added?**

   CNS #1: No.

   CNS #2: Wording changes need to be made on questions 16 and 17--from "participates in" to "contributes to."

   CNS #3: No, it looks good.

   NA #1: No.

   NA #2: No, you did a good job discerning advanced practice from general nursing practice.

   NA #3: One option would be around independent functioning; they may have a mentor, like a physician.

3. **The author intended the first 11 items to relate to clinical functions of the CNS. When you look at those 11 items, are there any there that do not relate to clinical functions?**

CNS #1: Nursing diagnosis in question 2 should not be there.

CNS #2: Items 1 through 6 and item 8 are not unique to the CNS role; general nurses do them. Question 7 isn't done by me.

CNS #3: (Referring to question 2): Who gives a rip about nursing diagnosis?

NA #1: No.

NA #2: No, they might have to do routine patient care if they were mentoring. It would be on the priority for the moment.

NA #3: It would relate in some settings. Here (long-term care), they are a consultant.

Should any be added?

CNS #1: No.

CNS #2: Add something about complex patient populations within systems.

CNS #3: No.

NA #1: No.

NA #2: No.

NA #3: No.

4. **Numbers 12-20 relate to educational functions. Are there any that don't belong?**

CNS #1: In question 15, the term "assistance" is unclear. Question 16 has not been a focus in our setting.

CNS #2: In questions 16 and 17, "participates in" does not tell whether the CNS is just a learner or whether he/she conducts the inservices and education.

CNS #3: Question 12 seems like a clinical function.

NA #1: No.

NA #2: It's important that they (CNSs) not get sucked into outside organizations. Pretty soon, all their time is spent on presentations. Visibility of the role is important, so they need to publish and be in health systems.

NA #3: Our institution (long-term care setting) is attached to the educational system and that forms a practical link.

Any that should be added?

CNS #1: "Develops handouts for patients and families" should be added to question 20.

CNS #2: Question 20 should read "...and/or the development of teaching materials, marketing them for patient use" instead of "...and/or membership activities."

CNS #3: No.

NA #1: No.

NA #2: No.

NA #3: No.

5. Questions 21-29 relate to administrative functions. Are there any that don't belong?

CNS #1: I don't do administration. Question 24 is not administrative.

CNS #2: Question 24 sounds like a job of a nurse manager instead of a CNS.

CNS #3: No.

NA #1: No..

NA #2: No.

NA #3: No.

Any that should be added?

CNS #1: No.

CNS #2: Add something about the CNS participating in a program regarding allocation of services and cost containment.

CNS #3: No.

NA #1: No.

NA #2: No.

NA #3: No.

6. Questions 30-37 relate to research functions. Are there any that don't belong?

CNS #1: In question 34, what does "evaluates the nursing process" mean?

CNS #2: Question 34 is unclear--do we evaluate effectiveness or the research process used? Question 26 was already covered in question 23.

CNS #3: No.

NA #1: No.

NA #2: What convinces people in administration is when they (CNSs) develop pathways and save costs.

NA #3: No.

Any that should be added?

CNS #1: Clarify "evaluates" and "research process."

CNS #2: Question 32 should instead read: "...according to accepted standards of scientific inquiry."

CNS #3: It all depends on your definition of "research."

NA #1: No.

NA #2: No.

NA #3: Didn't see anything about attaching practice to education and research, which is important. The advanced practice nurse needs to always keep in mind (even though their time is limited) that they have to educate the staff nurse to understand and apply research.

Section III

1. **Do any of the closed-ended questions need different choice options than the ones available?**

CNS #1: On question 3 (4), we do peer review with other RNs--not with other CNSs. Tell me what you mean in questions 11 and 12 by reassignment."

CNS #2: For question 2, our job description does not direct us to perform anything; We CNSs wrote our own job description and it doesn't say we have to do anything. For question 3 (4), our peers don't set the expectations, the peer review is on the performance evaluation. Question 11 is kind of a mess; so is 12.

CNS #3: In questions 11 and 12, what is meant by "expanded" position? Those two questions are too vague.

NA #1: Add "Don't know" to questions 2, 6, and 10.

NA #2: Not really.

NA #3: Question 3 was not a lot for us, but would be for others. Our job descriptions are mainly used when people are hired.

2. **Is this section readable with logical flow?**

CNS #1: Yes, except for the variety of meanings I could get from the options in items 11 and 12.

CNS #2: Yes. The most important feedback I get is when I go to conferences and present.

CNS #3: Yes.

NA #1: Yes.

NA #2: OK.

NA #3: OK.

3. Does any part of this section suggest bias?

CNS #1: No.

CNS #2: In question 3 (1), a job description isn't a method--it sets an expectation.

CNS #3: Not at all.

NA #1: No.

NA #2: No. It went heavy on role strain in terms of clarification. There is some role strain, everyone has some. It makes it sound like the CNS is a victim. The CNSs can advocate for themselves.

NA #3: No.

4. Are there any items in this section that you see as unnecessary?

CNS #1: Questions 11 and 12.

CNS #2: Question 2 and Question 3 (1).

CNS #3: No, but it has been such a long time since I have looked at my job description I'm not sure what it says.

NA #1: No.

NA #2: No.

NA #3: No.

5. Are there items you would recommend to be added?

CNS #1: Do some work on questions 11 and 12.

CNS #2: Question 3: "Provides feedback about role performance." Question 6: Provide a place for comments, since all choice options depend on the needs of individuals and skills of others.

CNS #3: Explain what "expanded position" means in questions 11 and 12.

NA #1: No.

NA #2: No.

NA #3: It needs to have questions that get at functioning independently.

6. Is there something important that we haven't covered?

CNS #1: No.

CNS #2: I already told you.

CNS #3: This is a repetitive question.

NA #1: No.

NA #2: No.

NA #3: Questions 7-10 are really relevant. Nurses, nurse practitioners, NAs, it's important who does what.

General Questions

1. Do you think the time it took to complete the questionnaire is reasonable?

CNS #1: Yes, this is not too long.

CNS #2: I suppose.

CNS #3: Very reasonable.

NA #1: It was reasonable.

NA #2: It was fine.

NA #3: The length was OK.

2. Was the print size adequate for ease in reading?

CNS #1: Fairly--could be a little larger.

CNS #2: Yes.

CNS #3: Sure.

NA #1: Yes.

NA #2: Yes.

NA #3: Yes.

3. How do you think the results of this survey might best be used?

CNS #1: Employers may possibly wish to know these results.

CNS #2: Congruence with CNSs and NAs in validating the importance of the CNS role in a system. To focus on areas of development if needing improvement.

CNS #3: Why are we spending all this time on roles? What it comes down to is: Can you do the job or not? I see advanced practice in the future doing away with role differentiation. Distinguishing roles causes divisiveness within the profession. These results will only be used by those who are hung up on roles.

NA #1: It may be interesting to see how health care changes affect the role.

NA #2: See how CNSs are utilized here and how it compares with other places.

NA #3: It seems different for long-term care, but general results are of interest.

CLINCAL NURSE SPECIALIST QUESTIONNAIRE

SUMMARY OF RESPONSES -- SECTION I

To improve clarity and readability, recommendations from formatting experts for changes in wording will be incorporated into the introduction for this section. For consistency, "organization" will replace "institution". A brief general instruction line was also deemed advisable, so will be added.

Questions	Responses (n=6)	Implications for Change
Q-1. Please indicate the type of institution with which you are affiliated.	PRIVATE COMMUNITY HOSPITAL (1) PUBLIC COMMUNITY HOSPITAL (1) OTHER (4)	The majority of the respondents used the "other" category, so the closed-ended options will be increased to include agencies other than hospitals.
Q-2. How many beds in your institution?	200 OR LESS (2) 201-400 (2) 401-600 (1) "O-P--no beds" (1)	Numbers of hospital beds do not fully reflect the various ways that CNSs are utilized, so this item will be deleted.
Q-3. What is your current title?	DIRECTOR OF PATIENT CARE SERVICES (1) PROGRAM DIRECTOR (1) DIRECTOR OF NURSING (1) CNS (1) GERONTOLOGICAL CNS (1) CNS/CM (1)	
Q-4. How long have you held this title?	BETWEEN ONE AND THREE YEARS (4) MORE THAN FIVE YEARS (2)	
Q-5. What is the title of the person to whom you report?	VP OF PATIENT CARE SERVICES (1) DIRECTOR, AMBULATORY SERVICES (2) ADMINISTRATOR (2) DIRECTOR, PATIENT CARE SERVICES (1)	

Questions	Responses (n=6)	Implications for Change
Q-6. How would you characterize your position in the organization?	TOP-LEVEL NURSE ADMINISTRATOR (2) MID-LEVEL NURSE ADMINISTRATOR (1) CNS (3)	
Q-7. What is the highest educational degree you hold?	BACCALAUREATE IN NURSING (1) MASTER'S IN NURSING (5)	
Q-8. How many CNSs were employed in your institution three years ago?	TWO (2) FOUR (1) FIVE (1) SIX (1) ELEVEN (1)	Three respondents were unsure. Formatting experts recommended the addition of the word "approximately" in order to allow for this.
Q-9. How many CNSs are currently employed in your institution?	TWO (2) FIVE (2) TEN (1) ELEVEN (1)	
Q-10. What do you project the number of CNS positions to be one year from now?	TWO (2) FIVE (2) TEN (1) ELEVEN (1)	
Q-11. How many CNSs in your institution are:	MASTER'S (16) OTHER (1)	
Q-12. Do you have any CNS positions currently unfilled in your institution?	NO (2) YES (1)	Q-12 & Q-13 were changed to a "skip" question (Dillman, 1978).
Q-13. If CNS positions are not filled, what do you see as the reason(s).	LACK OF APPLICANTS / QUALIFIED PERSON NOT AVAILABLE (1)	

Question	Responses (NAs = #, CNSs = @)	Implications

Q-14. Have any of the following changes in health care resulted in changes in CNS utilization in your organization? (*Circle all that apply*)

CHANGES IN HEALTH CARE:	CNS UTILIZATION CHANGE: No change	Let CNSs go	Hired more CNSs	Reassigned CNSs	Other
1. CAPITATED CARE	###@@				
2. DECREASED LENGTH OF STAY	##@				@
3. INCREASED PATIENT ACUITY	#@		@	#@	#
4. INCREASED USE OF UNLICENSED ASSISTIVE PERSONNEL	##@@				# (don't know)
5. ISSUES OF "TURF" BETWEEN PHYSICIANS AND NURSES	###@@				
6. CHANGE IN PHILOSOPHY ABOUT TYPE OF ADVANCED PRACTICE NURSE NEEDED	##@				## (don't know)

7. OTHER (*please elaborate*)
   - "No increase in CNSs, but time reallocated to patients with high acuity"
   - "Budget constraints"
   - "CNS utilization frequently depends on the priority or focus of the hour"

Although the majority of respondents chose the "No change" option, it was decided by the researchers to keep these items in the event that a larger study would yield significant findings.

Q-15. To what extent has your organization considered reassigning an experienced CNS to a staff nurse position?

Not at all ##@@ @ Great deal

Two of the respondents interpreted "reassignment" to mean temporary coverage of duties. Wording will be changed to clarify this.

Q-16. To what extent has your organization considered asking experienced non-master's prepared nurses to perform the functions of a CNS?

Not at all #@ #@ @ Great deal

SUMMARY OF RESPONSES -- SECTION II

Clifford Clinical Nurse Specialist Functions Inventory (CCNSFI)

In the interviews with the content experts following administration of the CCNSFI, there were very few changes recommended for the items relating to functions of the CNS. There were no recommendations for deletion of items, or of additions that are specific to the CNS role. Some suggestions for more clear wording were made for some of the items, and these suggestions will be sent to Dr. Rita Clifford.

Q-16. Participates in formal and informal inservice education for non-nursing personnel.
will be changed to
Contributes to formal and informal inservice education for non-nursing personnel.

Q-17. Participates in formal and informal inservice education for nursing personnel.
will be changed to
Contributes to formal and informal inservice education for nursing personnel.

Q-34. Evaluates the nursing research process.
will be changed to
Evaluates applied nursing research in the clinical setting.

				Not expected in the position	Slightly Important	Important	Very Important	Utmost Importance
				0	1	2	3	4
Q-1. Assess patient problems								
	N	Mean	Mode					
NAs (#)	3	3.33	3				# #	#
CNSs (@)	3	3.00	--			@	@	@
Total	6	3.17	3					
Q-2. Establishes a nursing diagnosis								
	N	Mean	Mode					
NAs (#)	3	2.00	3	#			# #	
CNSs (@)	3	2.00	--		@	@	@	
Total	6	2.00	3					
Q-3. Establishes long and short term goals for care of individual patients								
	N	Mean	Mode					
NAs (#)	3	2.67	--		#		#	#
CNSs (@)	3	2.00	2			@ @ @		
Total	6	2.33	2					
Q-4. Prescribes nursing interventions								
	N	Mean	Mode					
NAs (#)	3	3.67	4				#	# #
CNSs (@)	3	3.33	4			@		@ @
Total	6	3.50	4					
Q-5. Administers routine direct patient care								
	N	Mean	Mode					
NAs (#)	3	0.67	1	#	# #			
CNSs (@)	3	2.33	2			@ @	@	
Total	6	1.50	1,2					

				Not expected in the position	Slightly Important	Important	Very Important	Utmost Importance
				0	1	2	3	4
Q-6. Administers specialized direct patient care								
	N	Mean	Mode					
NAs (#)	3	1.33	1		# #	#		
CNSs (@)	3	2.00	--		@	@	@	
Total	6	1.67	1					
Q-7. Initiates health teaching to be done by other nursing personnel for patients and families based on nursing assessment								
	N	Mean	Mode					
NAs (#)	3	2.67	--		#		#	#
CNSs (@)	3	2.00	--	@		@		@
Total	6	2.33	4					
Q-8. Implements health teaching for patients and famililes based on nursing assessment								
	N	Mean	Mode					
NAs (#)	3	1.67	2		#	# #		
CNSs (@)	3	2.33	--		@	@		@
Total	6	2.00	2					
Q-9. Assesses quality of nursing care in specific area								
	N	Mean	Mode					
NAs (#)	3	2.67	3			#	# #	
CNSs (@)	3	3.33	4				@	@ @
Total	6	3.17	3					
Q-10. Promotes upgrading of nursing care in specific area								
	N	Mean	Mode					
NAs (#)	3	3.00	4		#			# #
CNSs (@)	3	3.67	4				@	@ @
Total	6	3.33	4					

	Not expected in the position	Slightly Important	Important	Very Important	Utmost Importance
	0	1	2	3	4

Q-11. Coordinates patient care with other disciplines or departments

	N	Mean	Mode				
NAs (#)	3	2.00	3	#		##	
CNSs (@)	3	3.33	4		@		@@
Total	6	2.67	3,4				

Q-12. Develops assessment and evaluation tools to assist staff in planning and providing care

	N	Mean	Mode				
NAs (#)	3	3.67	4			#	##
CNSs (@)	3	3.00	--		@	@	@
Total	6	3.33	4				

Q-13. Acts as consultant for nursing staff

	N	Mean	Mode				
NAs (#)	3	4.00	4				###
CNSs (@)	3	3.67	4			@	@@
Total	6	3.83	4				

Q-14. Acts as consultant for medical staff

	N	Mean	Mode				
NAs (#)	3	4.00	4				###
CNSs (@)	3	3.33	3			@@	@
Total	6	3.67	4				

Q-15. Provides assistance to nursing staff in meeting identified patient and family health education needs

	N	Mean	Mode				
NAs (#)	3	3.00	3			###	
CNSs (@)	3	3.00	--		@	@	@
Total	6	3.00	3				

	Not expected in the position	Slightly Important	Important	Very Important	Utmost Importance
	0	1	2	3	4

Q-16. Contributes to formal and informal inservice education for non-nursing health personnel

	N	Mean	Mode				
NAs (#)	3	1.33	1		# #	#	
CNSs (@)	3	1.00	--	@	@	@	
Total	6	1.17	1				

Q-17. Contributes to formal and informal inservice education for nursing personnel

	N	Mean	Mode				
NAs (#)	3	3.00	3			# # #	
CNSs (@)	3	2.33	--		@	@	@
Total	6	2.67	3				

Q-18. Serves as a role model for nursing students

	N	Mean	Mode				
NAs (#)	3	2.67	3			#	# #
CNSs (@)	3	2.67	--		@		@ @
Total	6	2.67	3				

Q-19. Assists with clinical and theoretical teaching of nursing students

	N	Mean	Mode				
NAs (#)	3	2.67	3			#	# #
CNSs (@)	3	3.33	3				@ @ @
Total	6	3.00	3				

Q-20. Contributes to the education of the public through participation in health oriented organization programs and/or membership activities

	N	Mean	Mode				
NAs (#)	3	2.33	2			# #	#
CNSs (@)	3	2.67	2			@ @	@
Total	6	2.50	2				

	Not expected in the position	Slightly Important	Important	Very Important	Utmost Importance
	0	1	2	3	4

Q-21. Participates in institutional committees which influence or determine policies affecting nursing practice

	N	Mean	Mode					
NAs (#)	3	3.00	--			#	#	#
CNSs (@)	3	3.67	4				@	@ @
Total	6	3.33	4					

Q-22. Takes leadership in defining, maintaining, and interpreting standards of nursing practice

	N	Mean	Mode					
NAs (#)	3	3.33	4			#		# #
CNSs (@)	3	4.00	4					@ @ @
Total	6	3.67	4					

Q-23. Participates in formal evaluation of nursing personnel

	N	Mean	Mode					
NAs (#)	3	1.00	--	#	#	#		
CNSs (@)	3	1.67	--	@	@			@
Total	6	1.33	--					

Q-24. Has responsibility for all nursing activities in a clinical area

	N	Mean	Mode					
NAs (#)	3	1.00	1		# #	#		
CNSs (@)	3	1.67	0	@ @				@
Total	6	1.33	0,1					

Q-25. Participates in decisions regarding employment of nursing personnel

	N	Mean	Mode					
NAs (#)	3	0.67	1	#	# #			
CNSs (@)	3	1.67	--	@	@			@
Total	6	1.17	1					

				Not expected in the position	Slightly Important	Important	Very Important	Utmost Importance
				0	1	2	3	4
Q-26. Participates in decisions regarding termination of nursing personnel								
	N	Mean	Mode					
NAs (#)	3	0.67	1	#	# #			
CNSs (@)	3	1.67	--	@	@			@
Total	6	1.17	1					
Q-27. Takes leadership in the development and maintenance of a system of peer review for nursing personnel								
	N	Mean	Mode					
NAs (#)	3	1.67	--	#		#	#	
CNSs (@)	3	0.33	0	@ @	@			
Total	6	1.00	0					
Q-28. Participates in evaluating conditions, resources, and policies essential to the delivery of nursing care services								
	N	Mean	Mode					
NAs (#)	3	2.33	2			# #	#	
CNSs (@)	3	3.00	--		@		@	@
Total	6	2.50	2					
Q-29. Monitors changing needs of clinical area and institutes appropriate change								
	N	Mean	Mode					
NAs (#)	3	2.00	--		#	#	#	
CNSs (@)	3	3.33	4			@		@ @
Total	6	2.67	4					
Q-30. Assesses the needs for nursing research in clinical area								
	N	Mean	Mode					
NAs (#)	3	3.33	3				# #	#
CNSs (@)	3	3.00	--			@	@	@
Total	6	3.17	3					

	Not expected in the position 0	Slightly Important 1	Important 2	Very Important 3	Utmost Importance 4

Q-31. Identifies relevant clinical questions appropriate for systematic study

	N	Mean	Mode				
NAs (#)	3	3.33	3			# #	#
CNSs (@)	3	3.33	4		@		@ @
Total	6	3.33	4				

Q-32. Plans nursing studies according to accepted nursing research standards

	N	Mean	Mode				
NAs (#)	3	2.67	3		#	# #	
CNSs (@)	3	3.00	--		@	@	@
Total	6	2.83	3				

Q-33. Conducts research relating to nursing practice

	N	Mean	Mode				
NAs (#)	3	2.33	2		# #	#	
CNSs (@)	3	2.33	2		@ @	@	
Total	6	2.33	2				

Q-34. Evaluates applied nursing research in the clinical setting

	N	Mean	Mode				
NAs (#)	3	2.33	--	#	#		#
CNSs (@)	2	3.50	--		@	@	
Total	5	2.40	--				

Q-35. Interprets to nursing personnel the results of nursing research

	N	Mean	Mode				
NAs (#)	3	3.33	4		#		# #
CNSs (@)	3	3.00	--		@	@	@
Total	6	3.17	4				

	Not expected in the position	Slightly Important	Important	Very Important	Utmost Importance
	0	1	2	3	4

Q-36. Assists nursing personnel in utilizing research to effect change

	N	Mean	Mode			
NAs (#)	3	3.00	--		#	#	#
CNSs (@)	3	3.33	3			@ @	@
Total	6	3.17	3				

Q-37. Communicates results of research through presentations and publications

	N	Mean	Mode			
NAs (#)	3	3.00	3			# # #	
CNSs (@)	3	3.67	4			@	@ @
Total	6	3.33	3				

SUMMARY OF RESPONSES -- SECTION III

Questions/Responses (NA = #, CNS = @)

Implications

Q-1. In your organization, is the CNS position description.....1. SPECIFIC FOR EACH CNS # @
2. GENERIC FOR ALL CNSs # @@
3. OTHER # (both)

Q-2. Does the job description contain language directing the CNS to perform: *(Circle yes or no for each)*

1. DIRECT PATIENT CARE.....Yes.##@@.....No @
2. INDIRECT PATIENT CARE.....Yes #@@.....No
3. STAFF TEACHING.....Yes. ###@@.....No
4. PATIENT TEACHING.....Yes.##@@.....No @
5. RESEARCH.....Yes.###@@.....No
6. CONSULTATION.....Yes.###@@.....No
7. COLLABORATION.....Yes.##@@.....No @

The wording in the stem question was offensive to one respondent, who stated that their job description did not " direct" CNSs to perform. Wording will be changed in the revised tool.

Q-3. Please rate the effectiveness of each of the following methods in clarifying expectations of the CNS role:

EFFECTIVENESS SCALE (1 = Lowest; 7 = Highest)

	Mean (NAs)	Mean (CNSs)	Mean (Total)
1. JOB DESCRIPTIONS	3.67	3.00	3.33
2. CNS QUARTERLY CONFERENCES WITH IMMEDIATE SUPERVISORS	4.00	3.33	3.67
3. REVIEW OF SELF EVALUATION WITH SUPERVISOR	4.33	4.33	4.33
4. PEER REVIEW	4.00	3.50	3.80
5. INFORMAL FEEDBACK FROM NURSE ADMINISTRATOR	5.67	7.00	6.33
6. INFORMAL FEEDBACK FROM OTHER NURSE COLLEAGUES	5.67	6.00	5.83
7. OTHER "Staff, other CNS, interdisciplinary input"			

In this small sample, informal feedback was rated, by far, the highest method for clarifying expectations of the CNS role.

Questions/Responses

Q-4. Who, in your estimation, are the top three role partners in your organization with whom a CNS must establish and maintain a relationship?

All three NAs identified the top role partner as the senior nurse administrator.
The CNSs varied in their responses: Other nurses, nursing directors and department managers were seen as topmost role partners.

Q-5. In your opinion, how effectively have the CNSs in your organization located and begun to establish relationships with the priority role partners for their practice in the first year of employment? (1 = Lowest; 7 = Highest) Mean: NA (5.00) CNS (3.75) TOTAL (4.29)

Q-6. Mentoring of novice CNSs may be done by a number of different people. For your institution, how would you rate the effectiveness of each of the following people in mentoring novice CNSs?

EFFECTIVENESS SCALE (1 = Lowest; 7 = Highest)

	Mean (NAs)	Mean (CNSs)	Mean (Total)
1. NURSE ADMINISTRATORS	5.00	3.00	3.80
2. OTHER CNSs	6.50	6.00	6.20
3. SELECTED STAFF NURSES	4.00	3.00	3.40
4. NURSE MANAGERS	4.00	3.00	3.40

Implications

The transition statement will be revised to clarify that these were only examples of some of the possible CNS role partners, since one respondent inditated feeling limited to the choices provided in the transition statement.

Another question will be added to allow comparisons between perceived effectiveness and importance, since this small sample raises interesting questions about role making.

Questions/Responses	(1 = Lowest; 7 = Highest) Mean (NAs)	Mean (CNSs)	Mean (Total)	Implications
Q-7. To what extent do you think CNSs in your institution experience role stress/strain?	4.33	2.67	3.50	One respondent expressed the opinion that role stress/strain for the CNS was overemphasized, since "everyone has it". The investigators felt that changing the items based on this one response would be premature. Need for furthur changes will be assessed as part of the next step in piloting the instrument.
Q-8. To what extent would you estimate role stress/strain to be a factor in CNS difficulties with job performance?	3.00	3.33	3.17	
Q-9. To what extent would you estimate role stress/strain as the major cause of resignations by CNSs in your organization?	2.67	2.67	2.67	
Q-10. To what extent would you estimate that terminations of CNSs in your organization have been related to unresolved issues of role stress/strain?	1.00	1.67	1.57	

Q-11. During the past two years, have any of the following happened to CNSs in your organization?
(Circle all that apply)

1. REASSIGNMENT TO AN EXPANDED POSITION
2. ASSIGNMENT TO DEVELOP A NEW PRODUCT LINE OR SERVICE FOR YOUR HOSPITAL/UNIT
3. REASSIGNMENT TO A LINE OR ADMINISTRATIVE POSITION
4. REASSIGNMENT TO ANOTHER SERVICE.....
   A. Within nursing service
   B. External to nursing service
5. OTHER (please explain)_____

Q-12. Do you envision any of the following changes happening to CNSs in your organization in the next two years?
(Circle all that apply)

1. REASSIGNMENT TO AN EXPANDED POSITION
2. ASSIGNMENT TO DEVELOP A NEW PRODUCT LINE OR SERVICE FOR YOUR HOSPITAL/UNIT
3. REASSIGNMENT TO A LINE OR ADMINISTRATIVE POSITION
4. REASSIGNMENT TO ANOTHER SERVICE
   A. Within nursing service
   B. External to nursing service
5. OTHER (please explain)_____

Questions 11 & 12 received many complaints regarding lack of clarity and non-applicability. The format will be changed to open-ended questions, allowing the respondents to identify and discuss issues of CNS role changes in their organization.

CLINICAL NURSE SPECIALIST QUESTIONNAIRE

Section I. THE QUESTIONS IN THIS SECTION ARE TO HELP US UNDERSTAND SOMETHING ABOUT YOUR ORGANIZATION, AND WHETHER CURRENT CHANGES IN THE HEALTH CARE ENVIRONMENT HAVE IMPACTED THE ROLE OF THE CLINICAL NURSE SPECIALISTS (CNSs) EMPLOYED THERE.

Please circle the number of the most appropriate response, and fill in the blanks as necessary

Q-1. With what type of organization are you affiliated?

1. UNIVERSITY HOSPITAL
2. PRIVATE COMMUNITY HOSPITAL
3. PUBLIC COMMUNITY HOSPITAL
4. FEDERAL AGENCY FACILITY
5. LONG TERM CARE FACILITY
6. OUTPATIENT/AMBULATORY CARE
7. OTHER_____

Q-2. What is your current title?

_____

_____

Q-3. How long have you held this title?

1. LESS THAN ONE YEAR
2. BETWEEN ONE AND THREE YEARS
3. THREE TO FIVE YEARS
4. MORE THAN FIVE YEARS

Q-4. What is the title of the person to whom you report?

_____

_____

Q-5. How would you characterize your position in the organization?

1. TOP-LEVEL NURSE ADMINISTRATOR
2. MID-LEVEL NURSE ADMINISTRATOR
3. CNS
4. OTHER_____

Q-6. What is the highest educational degree you hold?

1. ASSOCIATE DEGREE
2. DIPLOMA
3. BACCALAUREATE IN NURSING
4. BACCALAUREATE IN OTHER FIELD
5. MASTER'S IN NURSING
6. MASTER'S IN OTHER FIELD
7. DOCTORATE IN NURSING
8. DOCTORATE IN OTHER FIELD

Q-7. Approximately how many CNSs were employed in your organization three years ago?

1. NONE
2. ONE
3. TWO
4. THREE
5. FOUR
6. IF MORE THAN FOUR *(number)*_____

Q-8. Approximately how many CNSs are currently employed in your organization?

1. NONE
2. ONE
3. TWO
4. THREE
5. FOUR
6. IF MORE THAN FOUR *(number)*_____

Q-9. Approximately what do you project the number of CNS positions to be one year from now?

1. NONE
2. ONE
3. TWO
4. THREE
5. FOUR
6. IF MORE THAN FOUR *(number)*_____

Q-10. Approximately how many CNSs in your organization are:

MASTER'S PREPARED_____ DOCTORALLY PREPARED_____ OTHER_____

*(if other, please describe)*_____

Q-11. Are there currently any CNS positions in your organization which are considered necessary but are unfilled?

1. NO → *If "no", skip here to Q-13.*
2. YES

↓

(if "yes")

Q-12. If CNS positions are not filled, what do you see as the reason(s)? *(Circle all that apply)*

1. POSITION NOT BUDGETED
2. LACK OF APPLICANTS
3. QUALIFIED PERSON NOT AVAILABLE
4. REASON UNKNOWN
5. OTHER (*please elaborate*)_____

Q-13. Have any of the following changes in health care resulted in changes in CNS utilization in your organization? (*Circle all that apply*)

CHANGES IN HEALTH CARE:	CNS UTILIZATION CHANGE:				
	No change	Let CNSs go	Hired more CNSs	Reassigned CNSs	Other **
1. CAPITATED CARE	1	2	3	4	5
2. DECREASED LENGTH OF STAY	1	2	3	4	5
3. INCREASED PATIENT ACUITY	1	2	3	4	5
4. INCREASED USE OF UNLICENSED ASSISTIVE PERSONNEL	1	2	3	4	5
5. ISSUES OF "TURF" BETWEEN PHYSICIANS AND NURSES	1	2	3	4	5
6. CHANGE IN PHILOSOPHY ABOUT TYPE OF ADVANCED PRACTICE NURSE NEEDED	1	2	3	4	5

7. **OTHER (*please elaborate*)

_____

Q-14. To what extent has your organization considered permanent reassignment of an experienced CNS to a staff nurse position?

Not at all 1.....2.....3.....4.....5 Great deal

Q-15. To what extent has your organization considered permanent reassignment of experienced non-master's prepared nurses to perform the functions of a CNS?

Not at all 1.....2.....3.....4.....5 Great deal

Section II. THIS SECTION UTILIZES THE CLIFFORD CLINICAL NURSE SPECIALIST FUNCTIONS INVENTORY (WITH AUTHOR'S PERMISSION), AND FOCUSES ON THE IMPORTANCE OF SPECIFIC FUNCTIONS OF THE CNS.

	Not expected the position	Slightly important	Important	Very important	Utmost importance
Q-1. Assesses patient problems.	0	1	2	3	4
Q-2. Establishes a nursing diagnosis.	0	1	2	3	4
Q-3. Establishes long and short term goals for care of individual patients.	0	1	2	3	4
Q-4. Prescribes nursing interventions.	0	1	2	3	4
Q-5. Administers routine direct patient care.	0	1	2	3	4
Q-6. Administers specialized direct patient care.	0	1	2	3	4
Q-7. Initiates health teaching to be done by other nursing personnel for patients and families based on nursing assessment.	0	1	2	3	4
Q-8. Implements health teaching for patients and famililes based on nursing assessment.	0	1	2	3	4
Q-9. Assesses quality of nursing care in specific area.	0	1	2	3	4
Q-10. Promotes upgrading of nursing care in specific area.	0	1	2	3	4
Q-11. Coordinates patient care with other disciplines or departments.	0	1	2	3	4
Q-12. Develops assessment and evaluation tools to assist staff in planning and providing care.	0	1	2	3	4
Q-13. Acts as consultant for nursing staff.	0	1	2	3	4
Q-14. Acts as consultant for medical staff.	0	1	2	3	4

	Not expected in the position	Slightly important	Important	Very important	Utmost importance
Q-15. Provides assistance to nursing staff in meeting identified patient and family health education needs.	0	1	2	3	4
Q-16. Contributes to formal and informal inservice education for non-nursing health personnel.	0	1	2	3	4
Q-17. Contributes to formal and informal inservice education for nursing personnel.	0	1	2	3	4
Q-18. Serves as a role model for nursing students.	0	1	2	3	4
Q-19. Assists with clinical and theoretical teaching of nursing students.	0	1	2	3	4
Q-20. Contributes to the education of the public through participation in health oriented organization programs and/or membership activities.	0	1	2	3	4
Q-21. Participates in institutional committees which influence or determine policies affecting nursing practice.	0	1	2	3	4
Q-22. Takes leadership in defining, maintaining, and interpreting standards of nursing practice.	0	1	2	3	4
Q-23. Participates in formal evaluation of nursing personnel.	0	1	2	3	4
Q-24. Has responsibility for all nursing activities in a clinical area.	0	1	2	3	4
Q-25. Participates in decisions regarding employment of nursing personnel.	0	1	2	3	4

	Not expected in the position	Slightly important	Important	Very important	Utmost importance
Q-26. Participates in decisions regarding termination of nursing personnel.	0	1	2	3	4
Q-27. Takes leadership in the development and maintenance of a system of peer review for nursing personnel.	0	1	2	3	4
Q-28. Participates in evaluating conditions, resources, and policies essential to the delivery of nursing care services.	0	1	2	3	4
Q-29. Monitors changing needs of clinical area and institutes appropriate change.	0	1	2	3	4
Q-30. Assesses the needs for nursing research in clinical area.	0	1	2	3	4
Q-31. Identifies relevant clinical questions appropriate for systematic study.	0	1	2	3	4
Q-32. Plans nursing studies according to accepted nursing research standards.	0	1	2	3	4
Q-33. Conducts research relating to nursing practice.	0	1	2	3	4
Q-34. Evaluates applied nursing research in the clinical setting.	0	1	2	3	4
Q-35. Interprets to nursing personnel the results of nursing research.	0	1	2	3	4
Q-36. Assists nursing personnel in utilizing research to effect change.	0	1	2	3	4
Q-37. Communicates results of research through presentations and publications.	0	1	2	3	4

Section III. THIS SECTION RELATES TO ASPECTS OF CNS ROLE DEVELOPMENT.

Q-1. In your organization, is the CNS position description.....

1. SPECIFIC FOR EACH CNS
2. GENERIC FOR ALL CNSs
3. OTHER *(Please descibe)*_____

Q-2. Does the CNS position description include performance objectives in each of the following? *(Circle yes or no for each)*

1. DIRECT PATIENT CARE.....Yes.....No
2. INDIRECT PATIENT CARE.....Yes.....No
3. STAFF TEACHING.....Yes.....No
4. PATIENT TEACHING.....Yes.....No
5. RESEARCH.....Yes.....No
6. CONSULTATION.....Yes.....No
7. COLLABORATION.....Yes.....No

Q-3. Please rate the effectiveness of each of the following methods in clarifying expectations of the CNS role:

	EFFECTIVENESS						
	Lowest						Highest
1. POSITION DESCRIPTIONS	1	2	3	4	5	6	7
2. CNS QUARTERLY CONFERENCES WITH IMMEDIATE SUPERVISORS	1	2	3	4	5	6	7
3. REVIEW OF SELF EVALUATION WITH SUPERVISOR	1	2	3	4	5	6	7
4. PEER REVIEW	1	2	3	4	5	6	7
5. INFORMAL FEEDBACK FROM NURSE ADMINISTRATOR	1	2	3	4	5	6	7
6. INFORMAL FEEDBACK FROM OTHER NURSE COLLEAGUES	1	2	3	4	5	6	7
7. OTHER_____	1	2	3	4	5	6	7

According to role theory, role partners are those who interact with the role occupant in a variety of ways, in order to meet the expectations of the role. For example, CNS role partners may include nurse administrators, CNSs and other nurses, clients and families, physicians, and other health care providers.

Q-4. Who, in your estimation, are the top three role partners in your organization with whom a CNS must establish and maintain a relationship?

_____

_____

_____

Q-5. In your opinion, how effectively have the CNSs in your organization located and begun to establish relationships with the priority role partners for their practice in the first year of employment?

Lowest Highest
1.....2.....3.....4.....5.....6.....7

Q-6. Mentoring of novice CNSs may be done by a number of different people. For your organization, how would you rate the effectiveness of each of the following people in mentoring novice CNSs?

	Lowest						Highest
1. NURSE ADMINISTRATORS	1	2	3	4	5	6	7
2. OTHER CNSs	1	2	3	4	5	6	7
3. SELECTED STAFF NURSES	1	2	3	4	5	6	7
4. NURSE MANAGERS	1	2	3	4	5	6	7
5. OTHER_____	1	2	3	4	5	6	7

Q-7. For your organization, how would you rate the importance of mentoring by each of the following people?

	Lowest						Highest
1. NURSE ADMINISTRATORS	1	2	3	4	5	6	7
2. OTHER CNSs	1	2	3	4	5	6	7
3. SELECTED STAFF NURSES	1	2	3	4	5	6	7
4. NURSE MANAGERS	1	2	3	4	5	6	7
5. OTHER_____	1	2	3	4	5	6	7

According to role theory, role stress and strain result when expectations are contradictory or incompatible, (role conflict), when there is lack of clarity (role ambiguity), and when there is a difference between preparation for the role and the expectations of the role (role incongruity).

Q-8. To what extent do you think CNSs in your organization experience role stress/strain?

Lowest Highest
1.....2.....3.....4.....5.....6.....7

Q-9. To what extent would you estimate role stress/strain to be a factor in CNS difficulties with job performance?

Lowest Highest
1.....2.....3.....4.....5.....6.....7

Q-10. To what extent would you estimate role stress/strain as the major cause of resignations by CNSs in your organization?

Lowest Highest
1.....2.....3.....4.....5.....6.....7

Q-11. To what extent would you estimate that terminations of CNSs in your organization have been related to unresolved issues of role stress/strain?

Lowest Highest
1.....2.....3.....4.....5.....6.....7

Q-12. During the past two years, how has what CNSs do in your organization changed? For example, have they been reassigned to expanded roles? Have their roles been redefined? Have they assumed different responsibilities? If so, in what areas?

Q-13. How do you envision the role of the CNS changing in the future? How will this affect you?

Is there anything of concern to you about the CNS role that we have not covered?

July 4, 1995

Rita Clifford, RN, PhD
Associate Dean
University of Kansas School of Nursing
3901 Rainbow Blvd.
Kansas City, Kansas 66160-7501

Dear Dr. Clifford:

Thank you for giving your permission to use the Clifford Clinical Nurse Specialist Functions Inventory in our master's research project during this past year. The purpose of our project was to develop a composite questionnaire for measuring perceptions of the role of the CNS, using your inventory as part of the composite.

The composite instrument has three major sections. The first includes demographic data, as well as items relating to the changing health care environment. The second section consists of the CCNSFI. The final section is an augmented tool developed by us, with the assistance of our advisors, for identifying aspects relating to role theory. We felt that an augmented and/or revised instrument was indicated, with particular interest in: (1) addition of items in relation to current health care changes; (2) items that reflect a role theory framework; and (3) determining the current validity of the items on the CCNSFI.

Six content experts participated in our project, as well as three formatting experts. The six content experts consisted of three practicing CNSs here in Oregon, and their nursing supervisors. They were chosen because they were experienced with the CNS role and represented a variety of employment settings.

Only minor revisions in wording for some items on the CCNSFI were made as a result of feedback from the content experts. We have italicized these changes in the enclosed copy of the instrument.

Again, we thank you for your generosity in the use of the CCNSFI.

Sincerely,

Ramona C. Lewis
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Beaverton, OR 97007

Nadine M. Parker
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Gresham, OR 97080