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Résumé

Le volet consultation du rôle d'infirmière clinicienne spécialisée

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Au Canada, le rôle de l'infirmière clinicienne spécialisée (ICS) comporte cinq grands volets : l'exercice clinique, la consultation, l'éducation, la recherche et la direction. La présente étude porte sur le volet consultation, tel que décrit par les ICS, plus précisément sur les facteurs qui facilitent ou entravent sa mise en œuvre. Les auteures se sont fondées sur une approche qualitative et descriptive pour interroger 8 ICS qui travaillent auprès d'une population adulte dans un hôpital universitaire. Selon les données recueillies, gérer les situations de crise, assurer la continuité des soins et appuyer le travail des autres professionnels et équipes de santé constituent trois aspects essentiels du volet consultation. L'ambiguïté des rôles perçue par les autres professionnels ainsi que les demandes et attentes constantes attribuables à un milieu en constante évolution comptent parmi les principaux défis que doit relever l'ICS dans son travail. Ces facteurs exigent de l'ICS qu'elle clarifie constamment son rôle en fonction de l'époque et du lieu.

Mots clés : exercice clinique, infirmière clinicienne spécialisée, consultation

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The Consultation Component of the Clinical Nurse Specialist Role

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The clinical nurse specialist (CNS) role in Canada has 5 key components: clinical practice, consultation, education, research, and leadership. This study focuses on the consultation component: how it is described by CNSs and the facilitators and barriers to its implementation. A qualitative descriptive design was used to interview 8 CNSs who worked with adult populations in a university hospital setting. The findings indicate that managing crisis situations, ensuring continuity of care, and supporting other health professionals and health-care teams are key areas of consultation. Role ambiguity perceived by other professionals and constant demands and expectations due to a changing environment constitute the major challenges of CNS practice, requiring CNSs to continuously clarify their role in accordance with changes in time and place.

Keywords: advanced nursing practice, clinical nurse specialist, consultation

The clinical nurse specialist (CNS) is one of two advanced practice nursing roles in Canada (Canadian Nurses Association [CNA], 2008). In the Canadian Nurses Association's recent position statement on the role (2009), CNSs are defined as registered nurses who hold a master's or doctoral degree in nursing, have expertise in a clinical nursing specialty, promote excellence in nursing practice, and serve as role models and advocates for nurses by providing leadership and by acting as clinicians, researchers, consultants, and educators. They consult on complex cases, promote an evidence-based culture, and facilitate system change (CNA, 2009). CNSs have been shown to improve quality of care and patient outcomes, reduce costs, and support nursing practice and knowledge (CNA, 2009; Darmody, 2005; LaSala, Connors, Pedro, & Phipps, 2007; Sparacino & Cartwright, 2009; Urden, 1999). Fulton and Baldwin (2004) compiled an annotated bibliography of studies that evaluated CNSs and found that CNSs reduced hospital and emergency admissions, improved prenatal care, and reduced complications for cancer patients.

The CNS role was introduced in Canada in the 1960s as a direct response to the increasing complexity of both clinical care and the health-care system. Despite consistent descriptions of their role dimensions, CNSs struggle with role implementation. In a recent Canadian study of the advanced practice role (Pauly et al., 2004), CNS participants maintained that their knowledge and skills were being underutilized, their practice was constrained, and they were undervalued in their prac-

tice settings. These findings are consistent with those of studies completed in the 1990s, which also found that, despite a clear description of the role and the outcomes, the CNS role remained ambiguous (Davies & Hughes, 1995; Scott, 1999).

The National Association of Clinical Nurse Specialists (2004) in the United States describes the CNS in terms of three spheres of influence in the patient/client, nurses/nursing, and system/organizational fields. A comprehensive literature review (Lewandowski & Adamle, 2009) provides a detailed description of the CNS role and the outcomes achieved. However, recent studies have found that role blurring, inconsistent titles and education, lack of goal-setting for the CNS role, lack of understanding of the CNS role by other health professionals, and inadequate institutional support have contributed to ambiguity of the role (Bryant-Lukosius, DiCenso, Browne, & Pinelli, 2004; Lloyd Jones, 2005; Pauly et al., 2004). Lewandowski and Adamle (2009) claim that lack of understanding may be linked to the hidden work of the CNS and that the problem may be accentuated by the diversity within and across the role.

Given that CNSs consult with a variety of groups, including clients, other nurses and health-care providers, health-care organizations, and policy-makers, misunderstanding of the role could hamper its effective utilization and the achievement of positive health-care outcomes. As it is consultation competency that underpins the ability to introduce change, improve practice, and work within an interdisciplinary setting, it is essential that we deepen our understanding of consultation and the factors that may facilitate or inhibit this dimension of role enactment.

It is through the use of consultation and collaboration that clinical practice and systems improvement occur (Barron & White, 2009; Dunn, 1997). Historically, the CNS's consultation role dimension served well in complex situations by educating patients/families to respond to their own needs. More recently, clinical consultation has been described as a bridge between knowledge and practice, the primary goal being to promote the clinical expertise of nurses and other health professionals and so facilitate their empowerment (Barron & White, 2009; Lewandowski & Adamle, 2009). Further, innovation, change, and program development are part of the administrative consultative field.

Building on Caplan's (1970) work in mental health consultation, Barron and White (2009) build on the model, postulating four types of consultation based on the patients, the consultee, organizational needs, and the needs of individuals or groups experiencing difficulty with organizational objectives. The model, which focuses on the processes, outcomes, and characteristics of the players involved, informed our work. It describes the four-phase consultation process (assessment, intervention, evaluation, and reassessment) and the ecological field in which it takes

place. This field represents the interconnection and interrelation of the systems and contexts that influence the consultation process. The most important elements are the characteristics of the consultant (CNS), the consultee, and the patient/family as well as the situational factors that influence the purpose and outcomes of the consultation.

The purpose of this study was to describe the consultation component of the CNS role in a university hospital with an adult population. The research questions were four in number: *What are the goals and objectives of the consultation component of the CNS role? How does the CNS describe the consultation process? What are the contextual barriers or facilitators that influence the consultation component of the CNS role? What characteristics of the CNS (the consultant) and the consultee are necessary for consultation effectiveness?*

Method

Design

The study used a qualitative descriptive design based on a process of naturalistic inquiry. The aim of this approach is to understand and describe a phenomenon according to the experience of and meaning given to it by the participants (Loiselle, Profetto-McGrath, Polit, & Beck, 2004; Macnee, 2004). It allows for flexibility and adaptation to what is being discovered during data collection (Loiselle et al., 2004).

Setting and Sample

CNSs were recruited at a large urban university hospital, located in the Canadian province of Quebec, with a 20-year history with the CNS role. After approval had been obtained from the institution's Research Ethics Board, a letter describing the study was sent to all those CNSs employed in the hospital who worked with an adult population. CNSs who were master's-prepared and had at least 5 years' experience as a CNS were eligible to participate. Of the 16 CNSs who met these inclusion criteria, eight agreed to be interviewed.

Procedure

The primary researcher conducted individual semi-structured interviews in French or English with each CNS in the hospital setting. The interviews lasted from 60 to 90 minutes and were audiorecorded. Demographic data were also gathered. Barron and White's (2009) conceptual model, which inspired the development of the study, informed the interview questions and guided the analysis. The participants were asked to describe: (a) how consultation fit into their practice, (b) the consultation process, (c) the goals of consultation and indicators of consultation outcomes, (d) situational factors influencing consultation, and (e) the rela-

tionship/dynamic between the consultant and the consultee and the abilities required for successful consultation. The transcribed interviews were analyzed according to Miles and Huberman (2003). New data were compared and reviewed throughout the process, to ensure a comprehensive understanding of the phenomenon.

Ensuring Rigour

In order to attain rigour, the researcher must ensure authenticity, credibility, and confirmability (Graneheim & Lundman, 2004). Authenticity was ensured by validating the content interpretation with the two participants who provided the richest interviews, to confirm that the eventual findings reflected their experience. To ascertain credibility, the researchers independently coded the same interviews (inter-coder reliability). As themes and subthemes emerged, the researchers validated their findings with each other. Credibility of the results was further determined by validating the themes with an expert on the CNS role. Differences and similarities were discussed. Confirmability was ensured by keeping a journal (memo, audit trail) describing the research process and documenting decisions made throughout the study.

Results

All eight participants were women. They ranged in age from 41 to 60 years and had 11 to 40 years' nursing experience. Seven had between 5 and 10 years' experience in the CNS role and one had more than 11 years. Their specialty areas were medicine (including emergency medicine), surgery, neurosciences, cancer care, women's health, and mental health.

Goals and Objectives of the Consultation Component of the CNS Role

The participants described the main goal of their consultation activity as improving quality of care by sharing knowledge or making recommendations based on their expertise so that the consultee could plan appropriate patient care:

> *When someone calls me about a patient . . . you try to get them to think more broadly about the situation, which I think is definitely the role of the consultant. It's to get them to see it through a different set of lenses.*[1]

CNSs indicated that they spent between 20% and 75% of their time in consultation and that the volume of consultations was increasing, particularly in the areas of crisis management and especially at end of life

[1] In keeping with regulations regarding anonymity, only the primary investigator is aware of the identity of each participant.

and in conflicts between health professionals:

> *Particularly at end-of-life situations . . . the nurses think that the doctors should stop long before the doctors think that they should stop. So there's a lot of communication strain, so part of my job is to get the two sides talking.*

Crisis management also included addressing the needs of family members:

> *. . . actively treating families that are struggling with levels of care, incorporating what that means. It's elevating or actualizing family goals about comfort and perceptions of quality of life . . . then looking at how one moves a family or all the team.*

The CNSs who were consulted for complex and difficult cases often assumed responsibility for ensuring the continuity of a patient's care beyond their unit, across different settings and throughout the hospitalization:

> *I work with patients that transition across settings . . . the patient crosses many settings and sometimes my role is to make sure that there is continuity of care across those settings. It doesn't mean that the patient care needs related to our specialty have to suffer . . . Sometimes it's ensuring safety across settings too.*

The CNSs described sharing their knowledge with nurses, with interdisciplinary teams, and within their own specialty teams. Often, the knowledge they shared was perceived as a means of supporting the consultee or team as they increased their competence in dealing with a specific health issue. In one instance, the CNS was instrumental in having the team view the patient more holistically, which served to increase the team's ability to handle similar situations. One CNS stated that her goal with respect to consultation was to help consultees "do a reality check."

Consultation Process

The CNSs encountered major challenges relating to the consultation component of their role. All participants discussed the implications of working in an environment or within an organization that is constantly changing to adapt to new health-care realities, new technologies, and the complexities of patient/family care. They had to continually adjust their roles and adapt their competencies to the new demands. This resulted in role ambiguity, contributed to the lack of clarity concerning the role, and necessitated a constant shifting of objectives. The participants agreed that it was difficult even for them to delineate where one competency ended and another began. The multiple roles, often on the same unit, con-

tributed to the ambiguity. This was the case for clinical practice, education, and consultation:

> *There have been many changes at many levels related to the type of care that we provide. Also, patients are getting older. There are more referrals . . . to new technologies . . . they have more concomitant disease[s] that before they didn't have, and so the population has changed as well.*

In order to address the challenges, the CNSs used two strategies: constant clarification of the dimensions of their role and objectives with their colleagues, and participation in reflective practice. The participants adjusted their roles to meet the demands of the organization, the changing policies of the health-care system, new standards of care, and the monthly rotation of medical teams:

> *I'm functioning differently now than I was a while back. They need clarification of that and I need to put it into words, put it into a job description again or a description of my role within a project . . . roles that we're constantly being challenged to face.*

All CNSs working at this hospital took part in facilitated reflective practice sessions with trained facilitators. Reflective practice provided an opportunity to present cases or situations, examine behaviour, and refine and implement problem-solving strategies. CNSs felt that reflective practice empowered them to voice personal and system issues in order to transform and improve the quality of care with innovative interventions or new programs:

> *Basically, the goal of reflective practice is to have effective communication, so that when you find yourself in a situation you [can] think and respond to what is happening, to what is being said, in a way where you're facilitating the communication . . . Reflective practice enables you to communicate better . . . It stems from the art of negotiation.*

Contextual Factors Influencing Consultation

Facilitators of CNS consultation included administrative support, the influence of previous CNSs, role models, and peer support:

> *It was very encouraging to have the support of my director when I was expressing my vision. The nursing department is very supportive in promoting advanced nursing practice, the role of the clinical nurse specialist, and her status as a consultant.*[2]

[2] Free translation by the researcher, as the interview was conducted in French.

> *The access to people with experience in the CNS role is very helpful when you're trying to develop your own version of that role. So you have different models. I think it would be very difficult to be the first CNS, [to be] in a place where there had never been a CNS before, because you'd really be flying kind of blind . . . I've had the advantage of having a lot of different role models that I think were helpful.*

The CNSs identified interpersonal conflicts as a challenge to consultation activities. Conflicts emerged when there were differences of opinion between the CNS and other health professionals. These were particularly difficult when the CNS was consulted on a problem about which the person in the CNS role was viewed as having the expertise:

> *Sometimes the physician and I disagree as to what is the best plan of care. Those are always awkward to work with. I guess the ones that don't go well are when the information process doesn't necessarily go through . . . Sometimes there are underlying agendas.*

There was overlap between consultation and other role dimensions, such as education and research. Because of their relative lack of research experience, CNSs reported feeling inadequately prepared at the graduate level to undertake academic activities, such as teaching nursing students or acting as a student advisor:

> *Because you're meant to be an expert in research development . . . for example, mentoring three courses at the university . . . I felt totally unequipped to mentor anybody in the process of developing a clinical research project.*

Characteristics of the Consultant (the CNS) and the Consultee

CNSs reported that the success of consultation depended on the type of relationship between the consultant and the consultee and their individual attributes. Professional respect and collaboration were essential. Consultation was seen as the connecting of knowledge and clinical practice with the goal of promoting clinical expertise and empowering health professionals. In this regard, the ability to influence and negotiate with others (nurses, interdisciplinary teams, stakeholders) was seen as particularly beneficial:

> *I think involving a CNS in the care can be very good for patient outcomes. We have influence in terms of what actually happens to the patient, both in terms of educating the patient and [in terms of] affecting the quality of care that the patient receives. We make it go faster just by our very presence, and we clarify a lot of the ambiguity in the situation . . . The CNS*

has a lot of power. It's power of influence, power in terms of affecting the quality of care, influencing programs.

The participants explained that the CNS had to have two sets of abilities. The first set had to do with the individual CNS and included the ability to work on an interdisciplinary team, to influence and negotiate care modalities that are unique to the specific patient, and to move programs forward, as well as reliability and autonomy. The second type was described as competencies. These included expertise in role modelling and coaching as well as the skills required to engage in collaboration/partnership, empowerment, and advocacy.

Discussion

The CNS role is shaped by an understanding of advanced practice nursing, graduate education, organizational expectations, and expertise in a clinical specialty. By sharing their knowledge through consultation, CNSs increase nursing knowledge and effect change, which result in improved nursing practice, quality of care, and health outcomes. Their expertise enables them to negotiate across disciplines and settings with the objective of impacting nursing practice, resource allocation, and program development within the consultation dimension of the CNS role. The participants' power of influence and negotiation were linked to their expertise, leadership, reputation within the organization, ability to verbalize health issues, and past success in negotiating innovative care modalities.

Although CNS role competencies are described as separate entities, in reality they tend to overlap. The participants had difficulty delineating when consultation ended and education began and vice versa. The principal goal of consultation remains sharing knowledge in order to improve quality of care.

The consultation process used by the participants in our study was similar to that described in Barron and White's (2009) model, which guided the development of the research questions and interview guide. Our findings demonstrate that the consultation process is influenced by the relationship that develops between the consultant and the consultee, who each come to the consultation with his or her own characteristics and competencies. Contextual factors, challenges, and strategies also influence the consultation process.

The increase in requests for consultation in "crisis" situations (as identified by the participants) was seen as testament to the fact that the CNS is viewed as an expert in resolving such situations. This is consistent with the literature reporting the CNS to be a role model and skilled communicator with patients and families, team members, and other

health professionals (Ahrens, Yancey, & Kollef, 2003). The participants saw managing crisis situations as being different from managing complex situations, and as occupying much of their consultation time. To our knowledge, the element of crisis management is new in the literature. Development and tracking of indicators that demonstrate the impact and cost-effectiveness of the CNS role remain a source of frustration. However, the participants reported several informal indicators, such as number of consultations about conflicts between health professionals and family members or unplanned "hallway" consultations; these consultations were view by the participants as informal because they could not be linked directly to health-care improvement.

The participants in this study found their CNS role to be ambiguous on many levels. Despite efforts to clarify the role, they found that consultees often did not know when to consult the CNS because of constant shifts in roles and expectations. These factors are consistent with descriptions in the literature of role blurring and the invisibility surrounding the indirect work within the three spheres of influence: patient, nursing, and system (Bryant-Lukosius et al., 2004; Darmody, 2005; Davies & Hughes, 1995; Goudreau et al., 2007; Lewandoski & Adamle, 2009; Scott, 1999).

The participants were cognizant of the importance of addressing this ambiguity. Being well aware of what their role entailed, and knowing that the ambiguity stemmed from the changing expectations of their role in response to an evolving environment, they developed two strategies: role clarification, and reflective practice. Role clarification was a deliberate response to other health professionals' lack of understanding about their role and to the lack of clarity regarding their consultation competencies and objectives. The participants valued reflective practice as a way to develop professionally and solve problems effectively. They also perceived peer support as important, due in part to the diversity of their specialization and the fact that they faced similar system issues. Sharing experiences among each other was an enriching element.

Social Pertinence and Implications

The health-care system faces significant challenges, including a shortage of resources and an aging population requiring more complex and costly care. Our findings indicate that the CNS, by sharing expert knowledge, identifying and resolving health-care issues, responding to crisis situations, ensuring continuity of care, and building care teams, is instrumental in moving the system forward. The privileged position of CNSs in the health-care system enables them to implement, evaluate, and improve the quality of care as they assume the role of consultant in patient care.

This study provides relevant information for nursing leaders and administrators in developing and maintaining the consultation compo-

nent of the CNS role. In order to promote the value of the CNS in the health-care system, the role must be well defined and understood. Administrative support is crucial during development and implementation of the role. Role modelling and mentorship are essential to development of the consultation component of the CNS role, and reflective practice appears to be an interesting approach for improving practice and providing support. Education programs would provide CNSs not only with the theoretical foundation of advanced practice but also with the time and space they need to practise and to observe the implementation of the various role components, including consultation. Research must be given a more prominent place in the academic setting, as well as within the health-care organization, especially if CNSs are to participate in the expansion of nursing science.

Strengths and Limitations

A strength of this study is its examination of the consultation component of the CNS role from the perspective of the CNS. Limitations include the recruitment of CNSs from only one hospital, which was a large institution in an urban setting, and the collection of data from CNSs providing care to adult populations only. Future studies could examine the CNS perspective on the consultation component of their roles in other types of settings and with pediatric populations. They could also examine the perceptions of members of the health-care team about the consultation component of the CNS role.

Conclusion

The goal of this study was to describe the CNS consultation component in an adult hospital setting. Managing crisis situations, ensuring continuity of care, and supporting the development of individuals or health-care teams are key areas of consultation. Role ambiguity perceived by other professionals and constant demands and expectations from a changing environment constitute the major challenges of CNS practice requiring that they continuously clarify their role. It is essential that exploration and documentation of activities and outcomes related to the consultation component of their role be continued.

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