How useful is the expert practitioner role of the clinical nurse consultant to the generalist community nurse?

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KEY WORDS

Clinical nurse specialist, community health nursing

ABSTRACT

Objective
The objective was to draw attention to the clinical component of the clinical nurse consultants' (CNC) role in the community.

Design
Quasi-experimental research design that used descriptive statistics for data analysis.

Setting
An urban community nursing organisation comprising six community nursing Centres within the northern part of a major Australian city.

Subjects
A self selected sample of nine generalist community nurses (GCN) for a focus group. Information gained from this group informed the development of a questionnaire, which was sent to a convenience sample (n=125) of GCNs. Participation was voluntary and participants were not identified. Seventy-eight questionnaires were returned within the specified time frame, providing a return rate of 62.4%.

Results
Three main themes emerged:

- enabling the community nurses' role;
- accessing clinical knowledge\expert practitioner; and
- valuable resource.

The main reasons community nurses accessed CNCs were for clinical knowledge (73%) and problem solving (70%); the majority (82.9%) indicated visiting patient' homes with the CNCs was most useful.

Conclusion
As the complexity of patients' needs at home increase, CNCs have taken on an integral clinical role within the organisation. The positive working relationship between the CNCs and GCNs presumably had enhanced patient outcomes and improved patient health status. A significant strength of the survey was the consistent responses in favour of CNCs working in the community with the GCNs. A limitation is that the response rate was small (n=78) and results cannot be generalised. Results of this survey could serve to inform future work force planning.

INTRODUCTION

Management of illness in the home is the main focus of work of generalist community nurses (GCNs) employed by an organisation within the northern part of a major Australian city. Over the years, the complexity of patient care needs at home has increased with the introduction of innovative medical and nursing practices, for example peritoneal ports, pleural drainage, negative pressure wound closure systems and intravenous medications. It has also been recognised that an increasing number of patients living with cancer are requiring more complex care at home for longer periods (McKenzie et al 2007). Within the surveyed organisation, the clinical nurse specialist (CNS) positions are awarded on the basis of specialisation in community nursing generally, in contrast to community based CNSs in the United Kingdom (UK) who are specialists in a particular clinical field (McKenna et al 2003; Austin et al 2006). Therefore, in order to respond to the changes and challenges of providing high quality individualised patient care, the GCNs access Clinical Nurse Consultants (CNCs), who are the organisation's expert practitioners in the following areas: aged care and dementia, continence, oncology and palliative care, respiratory, spinal injuries, stomal therapy and wound management. The organisation is comprised of six Centres within the northern suburbs of a major Australian city. The Centres are geographically dispersed across 11 urban Local Government Areas within one New South Wales (NSW) Area Health Service. From January to December 2009, 7,756 patients received home nursing with a total of 127,612 hours of care provided.

Over ten years ago, a review of CNC positions within this organisation was undertaken (CNC Evaluation 1998). Since that time the CNCs have worked under a Performance Management Model. Under this model, individual CNCs negotiate an annual performance agreement, undertake six-monthly formal performance review and submit monthly reports to nurse management on work activities within five domains: clinical service and consultancy, clinical leadership, research, education and clinical service planning and management (NSW Department of Health Circular 2000/1).

It was apparent from the monthly reports that there are marked variances in levels of functioning within the domains. The majority of the CNCs' time is spent in one domain, that being clinical service and consultancy to GCNs, patients, their carers and other health professionals. In recognition of a focus on the CNC role within Area Health Services and acknowledging the increasing complexity of patient care needs in the home, a study was planned that would evaluate the GCNs' current experience of the CNC clinical role within their organisation.

LITERATURE REVIEW

The role of the CNC in NSW can be aligned to that of the CNS in the United States of America and Queensland, Australia (Vaughan et al 2005) and the Advanced Practitioner in the United Kingdom (UK) (Abbot 2007; Carnwell 2003). Generally in the overseas literature, studies focus on defining the CNC role (Ball 2005) or scope of practice, either through personal experience (Jinks and Chalder 2007; Fairley and Closs 2006; Coster et al 2006), through other health professionals' perspective's (McIntosh and Tolson 2009; McSherry et al 2007; Skingley 2006) or through evaluation of patient experiences (Hekkink et al 2005), which is similar to the Australian literature (O'Connor 2007; Vaughan et al 2005). Within the Australian literature, the Report on Evaluation of Clinical Nurse/Midwifery Consultants Roles (Nursing and Midwifery Office 2007) is a comprehensive review. Despite its length, the report concluded that there were a number of aspects of the role that required further discussion.

In recent years there have been major policy changes in NSW Health which have impacted upon community health services (Kemp et al 2002). Restructuring, financial constraints and the limited availability of health professionals have been experienced, particularly in rural areas (Woodhouse 2009). Kemp et al (2005 p.307), identified that 'patients at home are increasingly receiving a shorter, more intensive clinically focussed service, then being discharged from care, rather than receiving a lower intensity, multiple problem, more holistic service over a longer period of time'. If NSW Health follows trends reported

in the UK, there will be an increasing emphasis on community based interventions and treatment of more people closer to home (Heath 2006). In addition, the shifting of tasks from hospital to community health care has been reported in a Norwegian study that found such a development led to considerable professional pressure on community health care service providers (Gjevjon and Helles 2010).

As community nurses' workloads increase with new and/or more complex work, the nurses may need to look for support from expert practitioners. Searching the Australian literature specifically on CNCs working with community nurses revealed limited results (Downie et al 2005; Jannings and Armitage 2001; Jannings and Maynard 1998).

AIM

The aim of the study was to explore the perceptions and experiences of GCNs in relation to working with CNCs in the community setting. A questionnaire sought information from GCNs about their utilisation of the expert practitioners, reasons for use, difficulties experienced and their views of the CNC service.

METHOD

A focus group was seen as an effective way of generating descriptive information. An expression of interest was distributed across the six Centres inviting GCNs to attend a focus group to discuss the CNC role for purposes of a forthcoming survey. Participants were assured their anonymity would be maintained through the use of an objective, external facilitator. This resulted in a self-selected sample of nine nurses who participated in a two hour focus group. Analysis of the facilitator's report informed the project team in formulating the ten point questionnaire. The self-administered questionnaire comprised both qualitative and quantitative questions.

Six GCNs undertook a pilot trial of the questionnaire. No problems with ambiguity or misunderstandings were noted; no changes were made.

A two week survey period was set and the surveys were distributed.

Quantitative data were collated, coded and analysed using the Statistical Package for the Social Sciences (SPSS 16.0). Frequency statistics were used to analyse survey responses.

Qualitative data analysis took the form of thematic analysis. Separately, the project team read the responses to become familiar with the data. The GCNs' own words were coded, similar meanings were labelled and codes were clustered into groups that shared similar themes. The team met to discuss the analysis and consensus was reached.

Sample

Individually addressed questionnaires were posted to all eligible nurses (n=125), a convenience sample. Nursing Unit Managers (NUMs), acting NUMs, CNCs and any nurses on leave in the set period were excluded. A return addressed envelope and a cover sheet were attached to each questionnaire. The cover sheet explained the purpose of the study, who designed the questionnaire, that participation in the survey was voluntary and confidential and that participants responses would not be identifiable. A date was given for return of completed questionnaires.

Ethics

The Chair of the local Area Health Service Human Research Ethics Committee reviewed the proposal and approved the study.

FINDINGS

There was a 62.4% (n=78) response rate. Not all respondents answered every question. The unanswered (2.8%, n=22) questions were random, therefore the frequency results are presented with both the number and valid percentage of cases for each question.

Quantitative findings

Designations of the GCNs:

Sixty-one registered nurses (RN), nine CNSs and four endorsed enrolled nurses; four participants did not state their designation.

Accessing clinical and specialised / complex practice information:

No nurse accessed from one source only, the highest percentage (92.3%) of GCNs accessed the CNCs - See table 1. As the GCNs' work changes, they may no longer be able to rely on existing knowledge and experience. It would appear from the responses that GCNs are seeking out expert practitioners, talking to their peers and searching the electronic media for information to inform their own decision making in relation to patient treatment and care.

Table 1: Source of information accessed by GCNs.

Source	Number	% response	Source	Number	% response
CNC	72/78	92.3%	Intranet	19/78	24.4%
Other RNs	62/78	79.5%	Internet	17/78	21.8%
NUMs	56/78	71.8%	Preceptor	10/78	12.8%
CNS	49/78	68.2%	CIAP	9/78	11.5%
Community nursing service RN advisor	48/78	61.5%	Library	7/78	9%
GP	38/78	48.7%	Hospital team	4/78	5.1%
Nursing colleagues	29/78	37.2%			

GCN's views on CNC service:

From responses received, 93.1% (n=67/74) of the nurses stated that the CNC service met their needs; seven stated that a problem had occurred when either the CNC had been on leave or that there had been too long a delay in CNC response. A problem of highly specialised nurses is that it may be hard to get the appropriate cover whilst on leave. Although sick leave is an unplanned absence, the nurses have managers who could be called upon for advice. Regarding annual leave, the CNC should ensure that Centre managers have their leave notification, contact names, and numbers of relieving CNCs if available.

Frequency of CNC usage:

Consultation with CNCs ranged from 'a couple of times a year' to 'often daily'. The highest percentage (25.4%, n=18/71) accessed the CNCs four times per month. The mean was 7.5 times and median 4.0 times per month and demonstrated that the CNCs were well utilised.

Methods used to access a CNC:

All GCNs had used more than one method - see table 2. Mobile phone was the most popular method (87.2%). It was noted that few nurses use email (2.6%) as most do not have email provided by the organisation.

Table 2: Method used to access CNC.

Method of access	Number	% response
Mobile phone	68/78	87.2%
Face-to-face	66/78	84.6%
Landline phone	54/78	69.2%
Message book	48/78	38.5%
Fax	21/78	26.9%
Email	2/78	2.6%

Influence of CNC office location:

Some CNCs have offices at Centres, whilst others are non-Centre based. 62.3% (n=48/77) of GCNs stated that location did not influence their decision to contact the CNC and 37.7% (n=29/77) stated that it did. These results were surprising as each nurse is issued a mobile phone and has both fax and landline at their Centre offices and nurses can utilise these freely. Expert practitioners being highly visible makes a difference (Haycock-Stuart et al 2010), although travelling distances across the six Centres makes that option difficult.

Reasons for utilising the CNCs:

The main reasons the GCNs accessed the CNCs were for clinical knowledge (73%) and problem solving (70.5%) - see table 3. "Other" reasons included 'complex patient care' and 'for competency testing'.

Table 3: Reasons for utilising the CNCs.

Reason	Number	% response
Clinical knowledge	57/78	73%
Problem solving	55/78	70.5%
Support	44/78	56.4%
Education	32/78	41%
Other	15/78	19.2%

Usefulness of CNC clinical service

A five-point Likert Scale format was used to identify usefulness of the CNC clinical service across five categories - see table 4.

Of the five categories, 82.9% of GCNs (n=63/78) identified joint visits as the most useful. Joint visits involve the CNC going to the patient's home with the GCN to provide answers to specific questions, enhance skills and develop the GCNs' expertise. CNCs were recognised as trouble shooters (81.6%) and once called in can make the most of the opportunity by providing informal education (Jannings and Armitage 2001).

Table 4: Usefulness of CNC clinical service.

	Very useful	Somewhat useful	Neutral	Somewhat not useful	Not useful
Joint visits	82.9%	9.2%	3.9%	1.3%	2.6%
Trouble shooting	81.6%	13.2%	5.3%	-	-
Informal education	73.0%	20.3%	4.1%	1.4%	1.4%
Clinical decision making	69.7%	22.4%	7.9%	-	-
Formal education	66.2%	18.9%	10.8%	2.7%	1.4%

The quantitative data was further informed by the qualitative data.

Qualitative findings

From the GCNs views of this CNC clinical service, three strong themes emerged:

- enabling the community nurses' role;
- accessing clinical knowledge/ expert practitioner; and
- valuable resource.

Studies from the UK (Burt et al 2005; McIlfatrick and Curran 1999) and Australia (McKenzie et al 2007; Kemp et al 2005; Smith 2000) reveal that the work of the community nurse can be particularly complex and wide ranging. Amongst other avenues the GCNs had turned to the CNCs to utilise their expertise to inform their own practice:

> *'we can't be specialised in everything which is why the CNC is such a useful resource'.*

Community nurses work in isolation, unlike the availability of the ever present nursing team in the hospital setting. Supporting the community nurse role and enabling graduate nurses and nurses new to community nursing demonstrates the CNCs' positive impact:

> *'when I first started, the opportunity to speak with them about decisions I've made gave me comfort to deal with other patients'; and*

> *'as a new grad I was reliant on the CNC to provide safe and best practice. I believe the care I give would be compromised if there was not the role of CNC'.*

Two nurses stated that CNCs should have no direct patient contact, as this 'could undermine confidence' and 'CNCs should only be available for consultation back at the office'. The role of the CNC in collaboration with the community nurse is to support and work alongside. It should not be the intention of a CNC to take over or undermine the nurse's credibility in the eyes of their patient (Jannings and Armitage 2001; Jannings and Maynard 1998).

The majority of the respondents though, welcomed and benefited from the CNCs joint visits to patient's homes, the community nurses can also learn tacitly:

> *'joint visits provide practical support and advice that RNs may not at certain stages be able to provide, you can learn a lot from seeing them interacting with the patients'.*

When the GCNs are confronted with practice issues and needing to make sound decisions about the care they give to their patients, support is paramount:

> *'community nurses need to feel supported in their role, having a specialist nurse to speak to when issues arise enables an RN to manage a difficult role with greater professional knowledge and skill'; and*

> *'with their support, the anxiety and frustration experienced when dealing with complex issues is much relieved'.*

As their work is changing, GCNs need to employ best practice which will lead to better health outcomes for their patients. The CNCs can keep them up to date and engage them in evidenced based nursing as is their remit:

> *'they assist me to provide quality and skilled patient care, some of my patients would be in dire circumstances if it weren't for CNC input'.*

Additional information

A range of barriers to accessing CNCs were identified which require attention. One participant noted 'patient resistance', another 'inapproachability', and one stated that they had felt 'bullied in another area' on one occasion.

The wound CNC was given as an example many times as thought to be 'too busy so I don't bother (to call)', 'CNC not always available when required' and was 'not able to attend joint visits as soon as I want'. Four GCNs requested a second wound specialist nurse. If a CNC's perceived busy workload prevents referrals then strategic planning is required to manage the situation. If a GCN fails to contact the CNC, the effect is felt threefold - the quality of patient care may not be optimal, the GCN misses assistance in executing the nursing process and the CNC needs to be utilised if he/she is to perform effectively (Jannings and Maynard 1998).

One nurse stated - 'CNCs should be full time including weekends'.

One nurse stated that the stoma CNC should be employed full-time; while another was unaware the organisation employed a part-time stoma therapist, highlighting the need for a listing of available CNCs.

Strengths and Limitations

The survey did not evaluate CNC contribution on patient outcome, although the positive working relationship between CNCs and GCNs presumably enhanced patient outcomes and improved patient health status. The strength of the survey was the consistent responses in favour of CNCs working in the community with the nurses, but this may have been as a result of the survey design. The limitation of the survey was that the response rate was less than ideal (n=78), and the results cannot be generalised because it pertained to a particular group of CNCs. However, the findings presented in the paper will add to the community CNC practice literature.

A further option available for study would be CNCs working as expert practitioners within community services without the domiciliary nursing focus.

DISCUSSION

Generalist nurses 'have a broad knowledge base, and so their ability to keep abreast of the latest evidence in all areas of relevant practices maybe curtailed' (McKenna et al 2003 p.538). From the responses received, it would appear that the community nurses were aware of their limitations and had identified a wide range of avenues available to access information; the majority identified the CNCs as most utilised and useful.

CNCs are readily available and able to attend visits to patients' homes with the GCNs to educate, support and problem solve as required. According to the comments received, CNCs' clinical credibility was well recognised. In the McKenna et al paper (2003), deskilling, role conflict and confusion between specialist and generalist nurses had been noted in community settings, such concerns were not identified in this survey.

The identified enabling functions of the CNCs support previous findings of specialist nurses supporting generalist nurses in the community (Austin et al 2006;

McKenna et al 2003, Jannings and Armitage 2001; Jannings and Maynard 1998). The community based CNCs are the clinical leaders in their specialised fields (Haycock-Stuart et al 2010). Their effect in this study as clinical leaders influencing and nurturing other nurses' replicates findings elsewhere (Jinks and Chalder 2007).

A large volume of the workload of the CNCs in this survey is taken up by clinical demands. Lack of time would be the main constraint in preventing the CNCs from expanding their roles. This survey identified that the GCNs require the support of expert practitioners, therefore if the argument arises that CNCs should focus more on management, education and research (all part of their remit), then the community CNS role will need to expand to provide this specialty expertise, as is described within the literature (McKenna et al 2003; Austin et al 2006).

CONCLUSION

The results are based on a self-reported survey which captures experiences and perceptions from a small number of GCNs. The results cannot be generalised. Overall the survey demonstrated that the organisation's expert practitioners, the CNCs, were well utilised, respected, and viewed as supportive, effective resource persons by the community nurses. The CNCs' clinical service and consultancy provided the community nurses with appropriate support to meet new and complex nursing care challenges. Potential areas for further study were indicated, including CNC influence on patient outcomes.

As the complexity of patients' needs at home increase, CNCs have taken on an integral clinical role within the organisation. In the present era of Area Health Service budget restraints, results of this survey could serve to inform service planning and the future community health nursing work force.

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