

**From a Generic to a Gynaecological Oncology Clinical
Nurse Specialist: An Evolving Role**

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**A dissertation submitted in partial fulfilment of the requirements of the degree
of Master of Nursing at Otago Polytechnic, Dunedin, New Zealand**

March 2008

ABSTRACT

In New Zealand and internationally the clinical nurse specialist (CNS) is recognised as an essential member of the healthcare team contributing to improved patient outcomes. Nevertheless in the last decade the proliferation of CNS and other advanced nursing roles has resulted in confusion surrounding the nature and function of the role. This dissertation explores the role of the generic clinical nurse specialist (CNS) in order to provide clarity and guidance for an evolving Gynaecological Oncology CNS. An integrative literature review was undertaken to identify the generic components of a CNS role, the factors that impact on role development and, to establish what current literature states regarding the impact of the CNS role on patient outcomes.

The findings of the integrative review identified clinical expert, educator, consultant, researcher and care coordinator as generic components of a CNS role. Several factors were found to have influenced role development, such as, role preparation, role clarity and the support of the organisation, multidisciplinary team and nursing staff. The relational practice of a CNS was shown to be a key aspect in the improved patient outcomes and patient satisfaction. Improved service delivery and cost effectiveness were other positive outcomes associated with CNS practice.

The integrative review findings, selected literature and personal interpretation were incorporated to offer recommendations for an evolving

gynaecological oncology CNS role. This dissertation will contribute to a broader understanding of CNS roles and encourage discussion on the continued development of the CNS in New Zealand.

ACKNOWLEDGEMENTS

I would like to acknowledge my deep appreciation for the encouragement, patience, guidance and supervision given so freely by Judy Yarwood and Dr Daphne Manderson.

Thank you to all my nursing colleagues who have supported and encouraged me throughout my study.

Finally, I would like to thank David and my family for their love, support and enduring patience during my Master's journey. Without you all completing this journey would not have been possible.

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CHAPTER ONE: THE DEVELOPMENT OF THE CLINICAL NURSE SPECIALIST ROLE

In New Zealand (NZ) and internationally, the clinical nurse specialist (CNS) is recognised as an essential member of the healthcare team contributing to improved patient outcomes (Henderson, 2004; Heitkemper & Bond, 2004; LaSala, Connors, Pedro & Phipps, 2007; Ministry of Health [MOH], 1998). Changes in healthcare delivery as a result of social, political and professional forces have influenced the development of advanced nursing roles including that of the CNS (Cutts, 1999; Dyson, 1997; Hill, 2000; Scott, 1999). The CNS role continues to evolve in order to meet the needs of patients, nursing and healthcare organisations. There is however a need to describe and discuss this role in order to avoid the concomitant confusion over the role, function and activities of the CNS.

Litchfield (1998) argues that nurses need to be able to clearly articulate their own scope of practice in the context in which they work. Litchfield also suggests scope of practice is "the expression of the discipline of nursing in the work of the nurse" (p.13). The premise underpinning this dissertation is that it is essential for a CNS to demonstrate and articulate their contribution to patient care in order for the nursing profession,

employers, and the public to understand and appreciate what is expected from the role and the ways in which this role improves patient outcomes.

Purpose and Aims

The purpose of this dissertation is to reveal 'the nature' of the CNS role in order to increase understanding of the role and to provide clarity and evidence-based guidance for the development of an evolving gynaecological oncology CNS. The specific aims are:

- To conduct an integrative literature review in order to:
 - describe the CNS role in the acute care setting
 - identify the activities of a gynaecological oncology CNS
 - identify the factors that impact on the development of CNS role
 - demonstrate the impact of the CNS role on patient care
- Utilise the findings of the integrative review to explicate the gynaecological oncology CNS role.
- Identify opportunities for the development of the CNS role in New Zealand and highlight future research topics.

Background

Interest for this topic originates from reflection on my experiences of establishing and developing the role of a CNS in the gynaecological oncology specialty area over the last two years. At times this journey has been challenging, lonely, frustrating and satisfying but mostly I have a sense of 'growing' into the role. Many times I reflected on how the role has evolved and how it could be further developed to ensure the best patient outcomes. The following discussion will outline factors that have influenced the development of my role and then describe my current practice utilising the Nursing Council of New Zealand ([NZNC], 2001) advanced nursing practice competencies as a framework (Otago Polytechnic, 2007).

This particular CNS position was created to improve the quality of nursing care for women with gynaecological cancer. The service manager believed a CNS could provide leadership and model expert nursing practice. A generic District Health Board (DHB) job description provided the basis for writing the job description (see Appendix 1). The role is part time and it is anticipated the role would become fulltime as funding became available. In addition I work 20 hours a week as a staff nurse on the gynaecology ward. At times it is difficult to maintain boundaries between both roles and increasingly I am expected to undertake CNS activities on the days I work as a staff nurse with a full patient workload.

Personal resources I bring to the role include; thirty years clinical experience, including five years gynaecology and twelve years oncology

nursing, as well as the drive and passion to provide a quality nursing service for women with gynaecological cancer. Throughout my career I have continued my professional development and I have also undertaken post-graduate education working towards a Master's degree.

The role encompasses clinical work in an acute gynaecological area and an outpatient clinic. Initially, in clinical time on the gynaecology ward I concentrated on doing what I knew best, that is providing direct care to women with gynaecological cancer in the perioperative period. My focus was to improve the quality of nursing practice by modelling best practice, giving informal one-to-one teaching and presenting formal in-service education sessions. The other aspects of the role have evolved as I responded to patient problems and issues and learnt more about the importance of working in partnership (Christensen, 1998). In discussions with other CNSs in the DHB it became apparent there is wide diversity between these roles. This includes resources for roles, role development and how we actualise the roles despite generic job descriptions.

Resource issues have impacted on the development of my role. I received no orientation to the role or designated mentor. Lack of time and increasing workload has become an issue. At times I have struggled with boundary issues due to a lack of understanding of the role by members of the multidisciplinary team. These issues combined with a sense of floundering at times and making it up as I went, have contributed to feelings of frustration and at times a lack of job satisfaction.

The encouraging influences on my role development have been positive feedback from patients and families, collaboration with and support from the gynaecological oncologists, managerial support and a nurse colleague who initially provided informal supervision. I soon realised that clinical supervision would assist me to reflect upon and develop this role and consequently commenced formal clinical supervision. These issues combined with the need to identify evidence to support the development of my role, are the impetus for this dissertation.

My Current Practice

The philosophy underpinning my practice is the belief that the nurse-patient relationship is central to the provision of effective nursing care (Doane & Varcoe, 2007; Jonsdottir, Lichfield & Dexheimer, 2004; Kitson, 1999; O'Conner, 2005). Nursing requires the combination of the technological skills and knowledge (the science) with therapeutic caring (the art) and I strive to combine both to provide high quality patient-centred nursing care. I work in partnership (Christensen, 1998) and walk alongside patients and their families (O'Conner, 2003). A strength of my role is the ability to work collaboratively and independently along with the flexibility and autonomy I have been given by default to develop the role.

Competency one: Articulates scope of practice and its advancement.

I work within a gynaecology oncology multidisciplinary service which is situated in a large DHB that is a tertiary referral centre for a large geographical area. I work closely and collaboratively with three gynaecological oncologists to provide care to women of all ages throughout the cancer continuum. Care is episodic or continuous from referral for a diagnostic workup, or for treatment, rehabilitation, routine follow-up, recurrence and palliative care. The frequency of contact is determined by the needs of the women. My day-to-day clinical practice involves utilising advanced knowledge and skills to provide the interventions women and families require. Examples include providing direct and indirect care, informational, emotional and practical support, symptom management, triaging and arranging admission for assessment or further investigations, along with coordinating care with other services.

Competency two: Show expert practice, working collaboratively across settings within interdisciplinary environments.

I conduct comprehensive physical and psychosocial assessments. The knowledge and skills gained through post-graduate papers in advanced health assessment and pharmacology enables me to bring together all relevant findings. Included in this are results of tumour markers and other laboratory tests, radiological investigations including computed tomography (CT) and magnetic resonance imaging (MRI) in order to plan, implement and

evaluate nursing interventions required. Importantly my knowledge and skills enable me to further explain to women and families the results of investigations, the stage and grade of the cancer and potential treatment options. I am responsible for providing direct care and indirect care during the peri-operative phase and in follow-up outpatient clinics. My work involves the assessment and management of side-effects from cancer treatment, disease progression and discussion of psychosexual and psychosocial issues. I work collaboratively with oncologists and the palliative care teams to provide symptom management during the palliative stage and I initiate timely referrals to the multidisciplinary team.

The focus of my post-graduate education has been oncology nursing-related topics. This has contributed to the development of an extensive experiential and theoretical knowledge base in all aspects of oncology including genetics, carcinogenesis, chemotherapy, biotherapy, radiation treatment, palliative care and psychosocial effects of cancer. Having undertaken other professional development activities including: oncology short courses, national and international conferences, study days and training in communication skills and sexuality. I now have the ability to work with greater autonomy and have attained expert level on the DHB professional development recognition programme (PDRP) in my staff nurse role.

Competency three: Show effective nursing leadership and consultancy.

Modelling advanced skills to other nurses to improve the quality of nursing practice, has included regular ward teachings and using critical incidents as opportunities to provide guidance and education. I teach on the new graduate programme and coordinate and teach on a Gynaecological Cancer course at the local polytechnic. I am committed to the professional development of my colleagues and have previously taken on the role of clinical mentor for the Post-Graduate Certificate in Advanced Palliative Care at a New Zealand university. I am a resource person for PDRP.

I have established a network of oncology nurses and district nurses throughout the geographical area of the gynaecology oncology service in order to coordinate preadmission and ongoing physical and or psychosocial care as required post-discharge. This collaborative relationship enables nurses and general practitioners to contact me for information, advice and coordination of patient services. I work collaboratively with the Cancer Society to ensure patients have community supports and I assist with the local Cancer Society Gynaecological Cancer Support Group.

Coordination of a weekly multidisciplinary team meeting includes presenting case histories to social workers, physiotherapists, chaplain, pharmacist, medical staff, nurses, charge nurse, dietician and occupational therapist. The purpose of the meeting is to ensure complex discharge planning is facilitated and to initiate referrals to team members. I also attend a Gynaecological Tumour-Board meeting weekly with radiation oncologists,

medical oncologists, surgeons, pathologists, radiologists and junior medical staff. At this meeting all patients referred to the service are discussed, their histology and radiology results are reviewed and a multidisciplinary treatment plan is formulated. This is an opportunity for me to present my nursing assessment and act as patient advocate.

Competency four: Develops and influences health/socio-economic policies and practice at local and national level.

I have contributed feedback to the DHB Cancer Control Strategy, Palliative Care and Cancer Nurses' Educational Needs research project and participated in the DHB cancer services planning meeting. As well as contributing towards the development and review of DHB policies and procedures.

Being a member of the DHB Professional PDRP steering committee I have contributed to the development of the PDRP programme which is accredited by Nursing Council. I am also a member of the New Zealand Nurses Organisation (NZNO) Cancer Nurses Section and past national committee member. In this role I have contributed to the development of best practice guidelines, Cancer Nurses Standards of Practice, and provided feedback to the Ministry of Health Cancer Control Taskforce. I am a member of the New Zealand Gynaecological Cancer Group (NZGCG) which is an independent multidisciplinary association of health professionals and contribute a nursing perspective. I am also a member of the Oncology

Nursing Society (ONS) and have participated in an international oncology nursing delegation to China.

Competency five: Shows scholarly research inquiry into nursing practice.

I regularly undertake literature searches to answer clinical questions, to identify best practice and current research, or to provide patient information and to answer patient's questions. I have introduced and contributed to the development of best practice guidelines. I receive three specialty practice electronic journals monthly and I read relevant articles and research to ensure my practice is up to date and evidence based. All the ward teachings and lectures I present are referenced to relevant and current literature. I have presented at local study days, national and international conferences and used these opportunities to disseminate my specialist knowledge and skills.

I am a member of the Multidisciplinary Gynaecology Research Group investigating the informational and emotional needs of women with gynaecological cancer. I have also collaborated with the Cancer Society to organise a week of public meetings and professional study days to raise the awareness of gynaecological cancers.

Having described my current practice as a gynaecological oncology CNS and outlined my interest for undertaking this dissertation, the development of the CNS role in New Zealand and internationally will be briefly explored.

The CNS Role in Context

Christensen (1999) contends that the CNS role is “characterised by a completed clinical masters degree and clinical scholarship including practice-based research, as well as a focus of practice on nursing a particular population” (p.7). Although Christensen suggests this definition fits within the advanced practice role, she cautions against the use of the term ‘specialist’ with advanced practice as this can be confusing when all nurses practise within specialty areas. It is important to differentiate between specialty, specialist and CNS practice. Specialty refers to nursing practice which is focused within a specific area (Litchfield, 1998; NCNZ, 2001) for example palliative care or district nursing. Whereas, Christensen suggests specialist nursing practice refers to experiential and theoretical knowledge gained in a defined area of practice. Following this line of argument specialist knowledge and skills within a specialty area are components of CNS practice but it is the depth and breadth of these skills and the level expected of CNS practice which separates and defines the CNS role.

Castledine (2000a) and Finnie and Wilson (2003) also suggest that the confusion surrounding the CNS role, titles, and functions has been contributed to by the haphazard proliferation of the CNS role. Advanced practice nursing roles have emerged in many countries to improve the quality of patient care, the efficiency of health care and to provide a professional career pathway for clinical nurses (Castledine, 2002b). The development of these roles has often occurred in a reactive and random manner leading to ambiguity and confusion in relation to functions and titles

(Dyson, 1997; McCabe & Burman, 2006; Raja-Jones, 2002) and level of practice attributed to the titles (Kaur, 2003). Indeed Cox and Ahulwalia (2000) argue that the ambiguity and confusion pertaining to the title, function and role of the CNS can result in role fragmentation, and can negatively impact on the development and effectiveness of the role.

Sparacino (2005) suggests inconsistencies and differences in the development of a CNS exist as a result of the cultural, educational and socio-political context of each country. It is therefore important to consider the development of the CNS role in New Zealand within the context of international developments. The following section will briefly explore the development of the role in the United States of America (USA), the United Kingdom (UK), Australia and New Zealand.

The United State of America

In 1954 nursing scholar Hildegard Peplau is credited with establishing the first CNS Masters programme in the USA in Psychiatry (Dyson, 1997). Other specialty CNS programmes rapidly emerged and increased. Early CNSs were ward-based with the aim of improving the quality of nursing practice through consultation and direct care (Cohen, Crego, Cuming & Smyth, 2002). The proliferation of CNSs continued in the 1960s and 1970s resulting in the American Nurses Association (ANA) formally recognising the CNS. They defined the role as one of expert practitioner and change agent who was required to have a Master's degree

(Keeling & Bigbee, 2005). Oncology was one of the first specialty areas to establish a national organisation and in 1975 the Oncology Nursing Society (ONS) was created to support nurses working in the oncology specialty (Keeling & Bigbee, 2005). The title Oncology APN is endorsed by ONS and is given to designated nurses in NP, CNS or blended roles who have a master's degree within their specialty (Murphy-Ende, 2002; ONS, 2003).

The number of CNS positions increased until the 1990s at which time several factors contributed to the disestablishment of CNS posts (Bruce, 2006; Cohen et al., 2002; LaSala et al., 2007). Economic rationalisation (Bruce; Murphy-Ende, 2002), an increasing emphasis on primary health care and increasing numbers of nurse practitioners (NPs) (Keeling & Bigbee, 2005), blending of the CNS and NP role (Heitkemper & Bond, 2004), and organisational restructuring (Cohen et al.) were amongst these factors. However, increasing complexity and acuity of patients (Murphy-Ende) and the need for "strong mentoring on nursing staff" (Hamric, Spross & Hanson, 2005, p.xv) has seen this trend reversed resulting in a growing demand for CNSs. Walker, Gerrard, Bayley, Coeling, and Clark (2003) report a corresponding increase in Masters degree CNS programmes of twenty one percent since 1997. They posit this is a result of renewed employer demand for the CNS role. In some states CNS practice includes prescriptive authority and the ability to generate revenue by charging for services, thus making these positions more attractive and sustainable to prospective employers (Rose, Ali & Gresham, 2003).

In the USA the generic term 'advanced practice nurses' (APNs) encompass four nursing roles: CNS, NP, certified nurse-midwife and nurse anaesthetist (National Council of State Boards of Nursing [NCSBN], 2007; Murphy-Ende, 2002; Oberle & Allen, 2001). Bryant- Lukosius, DiCenso, Browne & Pinelli (2004) suggest legislation, regulation and title protection for these roles has resulted in greater clarity in distinguishing APN roles, however literature suggests the CNS role remains the most contentious of these roles. A strength of the CNS in the USA is the unity and strategic development of the role promoted by the National Association of Clinical Nurse Specialists (NACNS) (Murphy-Ende) This unity has been recently demonstrated in the generation of mountains of feedback to the NCSBN in response to a draft vision paper on advanced practice. This resulted in a decision by the NCSBN to reverse its earlier recommendation in the vision paper that CNSs would no longer be considered APNs and as such no longer be regulated or have title protection (Hudspeth, 2007). This model of APN roles is in contrast to the United Kingdom (UK) position where advanced practice is viewed independently of the CNS role (Castledine & Mason, 2003).

The United Kingdom

In the UK the CNS role emerged twenty years later in order to retain experienced nurses in clinical practice by providing a career pathway which recognised clinical expertise in a designated specialty (Castledine, 2002a;

United Kingdom Central Council [UKCC], 2002). Physician shortages in the 1990s, the move to develop professional career pathways, and governmental strategies to improve health services resulted in an increase in the number of CNSs (Castledine, 2002b). This resulted in an inconsistency in titles, roles and salary grades contributing to confusion regarding the role (Castledine 2002a; Cattini & Knowles, 1999; Hopwood, 2006). The UKCC set standards for specialist practice and education in 1995 and defined specialist practice as “the exercising of higher levels of judgement, discretion and decision-making in clinical care” (2001, p.1). ‘Specialist’ practitioner is a recordable qualification on the UKCC register. This qualification is not specific to the CNS role and any nurse who fulfils the set criteria can apply to the UKCC to record the ‘Specialist’ qualification. More recently there has been a shift from a focus on roles and functions to a focus on the level of practice (Royal College of Nursing ([RCN] 2003; UKCC, 2002; Coombs, Chaboyer & Sole, 2007).

The Nursing Midwifery Council ([NMC], formerly the UKCC) has developed a framework for post-registration nursing (NMC, 2005). This sets the standard for one role, an Advanced Nurse Practitioner, which is regulated and title protected and is similar to the NP role in the USA, Australia and New Zealand. As yet, there is no clear definition, and no standard set for the educational level (Raja-Jones, 2002), registration or professional recognition of CNSs in the UK (Coombs et al., 2007).

Australia

The CNS role was introduced in Australia in 1986 as part of a new clinical career pathway to retain experienced nurses at the bedside, the CNS title is awarded to experienced nurses by employers (Elsom, Happell & Manias, 2006; Pelletier et al., 1997; Walker, 2005). Although all states introduced the CNS role, the pathway differs between states and according to Kralik, Smith and Kelly (2006) there are wide variations in the role and function of the CNS. Ball and Cox (2003) define the role of a CNS as a “direct caregiver designated as competent in a specialist area of practice by an employing authority” although the criteria for demonstrating competence may vary between employers. (p. 357). It is suggested the clinical nurse consultant (CNC) role demonstrates more similarities to the American CNS role (Ball & Cox; Elsom et al.; O’Baugh, Wilkes, Vaughan & O’Donohue, 2007; Pelletier et al., 1997). Pelletier et al. argue the lack of a post-graduate degree is the reason for the fundamental difference between the Australian and American CNS role. Recent literature appears to indicate the CNS role in Australia is evolving to resemble the CNS role in the UK and USA (Dunn, Pretty, Martin & Gassner, 2006; Gardner, Change & Duffield, 2006; Yates, et al., 2007).

A more recent development is the NP role which is generating debate on the role and future of the CNS. Gardner et al. (2007) in an Australian qualitative study of nine advanced practice nurses (APNs) functioning in different roles, determined that APN is based on “a breadth of abilities and

skills” rather than clinical practice based on specialty knowledge and skills. They define APN as “those nursing roles that involve higher level of knowledge and skills that enable clinicians to practise with autonomy and initiate nursing actions but do not include diagnostic and treatment decision-making” (p. 383). This definition therefore includes the CNS role and specifically excludes the NP role, because as Gardener et al. state, diagnosis and treatment are the hallmark of the NP. Elsom et al. (2006) argue that the functions of a CNS and NP differ but the roles are complementary and both roles are required to meet healthcare needs in Australia.

Currently, there is no set standard for educational preparation, registration or regulatory requirement for the CNS role in Australia. Some authors agree that educational preparation for the CNS role should be at post-graduate level but no consensus has been reached regarding the entry level (Dunn et al., 2006; Wilson, 1999; Yates et al., 2007).

New Zealand

The introduction of the CNS role in the 1970s and 1980s met with limited success (Christensen, 1999). Some of these roles were incorporated within clinical career pathways (CCPs) to recognise the clinical expertise of nurses, political change in the form of the Employment Contract Act (1991) resulted in fragmentation of the nursing profession and CCPs were not implemented (Isles, 2006).

Over the last decade there has been a proliferation of CNS positions, evidenced by data from two hospitals in one DHB. The number of CNSs increased from 14.2 in 1997 to 47.2 in 2007 (Lewis, K., personal communication, November 1, 2007). In 1998 the Ministerial Taskforce on Nursing identified barriers the nursing profession faced in contributing to improved healthcare delivery in New Zealand. The Ministerial Taskforce identified CNS roles could contribute to improved patient outcomes. Furthermore there was a need for these roles to be “recognised and endorsed by Nursing Council” (MOH, 1998, p.28). The Taskforce recommended Nursing Council develop competencies for New Zealand nursing that are “linked to nationally consistent nursing titles, so that all nurses using a particular title can be recognised as having particular competencies” (p.38). In response the NZNC (2001) developed a framework for post registration education which specified the standards for specialty and advanced nursing practice. They specifically did not align this framework to titles nor did it define or utilise ‘specialist’ within the framework. Nearly a decade has past since the Ministerial Taskforce made its recommendations for the CNS role and these are yet to be implemented, NZNC has no plans to define CNS competencies at this stage (Doole, P., personal communication, December 5, 2007).

The CNS role is acknowledged both as an advancing and advanced practice role in New Zealand (MOH, 1998, 2002; Forde, 2007; Harris, 2007; Jacobs, 1998; Nurse Executives of New Zealand [NENZ], 2006). Kent et al. (2007) identified there is confusion surrounding the plethora of titles for

advanced practice roles. The need for national consistency in designated nursing titles has been recognised by nursing organisations (National Nursing Organisations [NNO], 2005; NENZ, 2006). In 2006, as part of the industrial agreement between New Zealand Nurses Organisation (NZNO) and District Health Boards of New Zealand (DHBNZ) consistent job titles and role descriptors for designated senior nurses were developed (NZNO, 2006). The descriptors were based on job descriptions from DHBs, feedback from senior nurses and Directors of Nursing as well as the NENZ position statements on nursing roles (Brown, C., personal communication, May 7, 2007). This CNS role descriptor is the result of an industrial process rather than the nursing profession using an evidence-based approach to define this role.

A review of nine CNS job descriptions within New Zealand demonstrates variations in role components and educational qualifications required (see Appendix 2). Isles (2006) conducted a comprehensive literature review and concluded the CNS role in New Zealand has achieved varying degrees of success in terms of improving nursing practice largely due to individual nurses being required to develop and define their own role. The Health Practitioners Competence Assurance Act (2003) requires NZNC to set competencies and standards of practice to ensure the public is protected (NCNZ, 2007). NZNC has defined four scopes of practice. CNSs work within the registered nurse (RN) scope of practice and are required to demonstrate competent level of practice to NZNC to maintain an annual practising certificate. Currently employers must determine the level of

practice required to fulfil the CNS role and if CNSs competently practice at the desired level through an annual performance review with the job description as the basis for the review.

According to Jacobs (2000) a decision was made in 1999, to regulate only one advanced practice nursing role in New Zealand, the NP. Title protection, formal recognition and regulation by NCNZ were afforded this role. Hickmott (2007) questions whether advanced practice nursing is confined to the NP and CNS roles as there are a variety of understandings of what is meant by the term advanced nursing practice in New Zealand. Kent et al. (2007) suggest the variety of advanced nursing titles has created confusion in the minds of nurses. The College of Nurses, Aotearoa (2006) also argues this confusion is shared by nurses, employers and the public. Furthermore, the College of Nurses, Aotearoa proposes a national debate should focus on the skills and competencies to be expected of expert nurses rather than on titles. Similarly, Hickmott (2007) presents this situation as a challenge for the nursing profession to debate a contemporary definition of advanced nursing practice. Currently there is no national standard set for the educational preparation, registration or regulation of the CNS in New Zealand.

The resurgence of the CNS role Heitkemper and Bond (2004) argue presents an opportunity to define the role and scope of practice. Furthermore, they also posit that the full potential of CNS role is still to be realised. Having discussed the development of the generic CNS role in the

USA, UK, Australia, and New Zealand, a brief overview of the socio-political context of cancer care and oncology nursing in New Zealand is provided.

The Socio-Political Context of Oncology Nursing in New Zealand

Improving the health of New Zealanders and specifically reducing the incidence and impact of cancer is a focus of government initiatives made explicit in the New Zealand Health Strategy (MOH, 2000), the New Zealand Cancer Control Strategy (MOH, 2003), the New Zealand Cancer Control Strategy Action Plan 2005-2010 (MOH, 2005a) and Access to cancer services for Maori (2005b). The overall purposes of these MOH strategies are to reduce the incidence and impact of cancer and reduce inequalities of different population groups through improving access to cancer services.

A key issue for New Zealand is the disparities in cancer registrations and cancer-related deaths between Maori and non-Maori (MOH, 2003; MOH, 2005a; MOH, 2005b). Reasons for disparities in Maori health is complex and results from a complex mix of factors such as socio-economic and lifestyle factors, a history of discrimination and an issue of access to culturally safe healthcare (Ellison-Loschmann & Pearce, 2006). Goal five of the Cancer Control Strategy is to improve the delivery of cancer services throughout the cancer continuum (MOH). A key objective of the MOH Action Plan (2005) to achieve this in relation to cancer nursing services is the need to build the “capability” of cancer nurses and define the scope of practice for “senior” oncology nurses (p.91). In response, a study by Kent et al. (2007)

on the educational needs of cancer and palliative care nurses identified a lack of clarity related to the criteria for attaining advanced oncology nursing roles. This study identified the need to define the scope of practice for senior oncology nurses and a clinical pathway for advanced oncology nurses.

Dissertation Outline

This dissertation has three chapters. Chapter One presented the rationale for exploring the CNS role and its significance to the provision of quality nursing care. My current practice as a gynaecological oncology CNS was described. The development of the CNS role in NZ within the context of international developments was also discussed. In chapter two an integrative review is undertaken to explicate the generic CNS role. In chapter three as a result of my analysis of the findings of the integrative review the implications for practice are integrated with literature to offer recommendations for the gynaecological oncology CNS role. Opportunities and challenges for this evolving role and the development of the CNS role in New Zealand are suggested and recommendations for future research conclude this dissertation.

Conclusion

This chapter has discussed the interest and background for exploring the CNS and the significance of the role to the provision of quality nursing care. Advanced practice nursing roles have emerged in many countries to improve efficiency of healthcare, the quality of patient care and to provide a professional career pathway for clinical nurses. However the haphazard proliferation of roles has resulted in confusion surrounding the CNS role, titles, and functions of the CNS role. An overview of the development of the CNS role in the USA, UK, Australia and New Zealand has demonstrated the influence of the American CNS role in other countries, though the roles differ between countries. The CNS role in the USA is regulated with a minimum entry level of Masters' degree education. In New Zealand the Ministerial Taskforce (MOH, 1998) identified CNS roles could contribute to improved patient outcomes and recommended the Nursing Council should endorse the role. Nursing Council is yet to act on this recommendation. Currently, there is no national standard set for the educational preparation, registration or regulation of the CNS in the UK, Australia and New Zealand.

The focus of governmental health (MOH, 2000, 2003, 2005a, 2005b) strategies in New Zealand are to reduce the incidence and impact of cancer and reduce inequalities through improving access to cancer services. This includes developing the capability of the oncology nursing workforce and specifically defining the scope of practice and pathway for advanced oncology nursing roles.

The overall goal of this dissertation is to explore and describe the generic CNS role with the aim of providing clarity and evidence-based guidance for a gynaecological oncology CNS. In the next chapter an integrative review will be undertaken to explicate the role of the CNS.

CHAPTER TWO: INTERGRATIVE LITERATURE REVIEW OF THE CLINICAL NURSE SPECIALIST ROLE

Having provided a background to this dissertation, this chapter explains the rationale for choosing an integrative literature review, and describes the methodology. Finally, the findings from the literature reports on and discusses the key concepts.

An integrative literature review as the methodological approach to examining the literature was made on the basis that it is a logical and systematic process. Kirkevold (1997) and Whitemore and Knafl (2005) argue that it is a method well suited to building nursing knowledge and informing practice as it allows for the integration of diverse research methodologies, empirical research and theoretical literature.

The purpose of an integrative review is to identify the current understanding of the research topic through a systematic process of analysing, summarising and synthesising completed research. According to Whittmore & Knafl (2005) there is an inherent risk of combining disparate research methodologies and varied data as well as the potential for inaccurate conclusions. In order to limit bias, strengthen the rigour and validity of findings, it is argued integrative reviews should be conducted with the same methodological standards as primary research (Ganong, 1987;

Polit & Beck, 2004; Russell, 2005). The five stages of an integrative review are:

- 1) Identifying the research problem, question or hypothesis to focus the scope of the review
- 2) Systematic and thorough literature search and data collection
- 3) Data evaluation
- 4) Explicit and systematic data analysis and lastly
- 5) Interpretation and presentation of findings (Russell, 2005; Whitemore & Knaf, 2005)

Research Questions

The purpose of this integrative review is to identify, analyse and synthesize nursing literature in order to describe the generic role of a CNS and increase understanding a gynaecological oncology CNS. Research questions guiding this integrative literature review are:

- I. What are the generic role components of an acute care CNS?*
- II. What are the activities and skills of a generic CNS role relevant to a gynaecological oncology CNS?*
- III. What are the factors that affect the development of a CNS role?*
- IV. How does a CNS impact on patient care?*

Search strategy

Comprehensive and systematic searches on OVID, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline and ProQuest were undertaken. The keyword CNS was combined with each of the other keywords and included: advanced practice, role definition, role clarity, role development, activities, skills, neoplasm, cancer and gynaecological cancer. Truncation symbols and Boolean connectors AND, OR were used to combine terms in order to broaden and focus the search. In addition, the search engine Google Scholar, the NZNO Library of New Zealand Research, online journals such as Oncology Nursing Forum and European Journal of Oncology Nursing were searched using the same keywords. Reference lists of relevant articles were also reviewed to identify further literature. The search was not limited to empirical research. Clinical and review literature, governmental and professional nursing organisation documents were also included. Beyea and Nicoll (1998) suggest reviewing this literature can be helpful in identifying and organising key issues to be addressed in this review. Email dialogue with an Australian author who described a clinical ladder for CNSs provided answers in relation to the CNS model (Walker, K., personal communication October 2, 2007). A plethora of literature was identified through this process.

Inclusion criteria: The plethora of literature identified required narrow inclusion and exclusion criteria to limit the scope of the project. The focus of this research was limited to CNSs working with adults in medical-surgical

hospital settings. To present a current perspective, research published from 1997-2007 was eligible. Studies from the USA, UK and Australia were included. These countries were chosen on the basis that the CNS role originated in the USA (Dyson, 1997; Keeling & Bigbee, 2005); New Zealand and the UK have similar public healthcare systems and similar socio-political factors. New Zealand nursing organisations and medical associations collaborate in research and bench marking activities with Australia and New Zealand (Australia New Zealand Gynaecology Oncology Group, (n.d)). Both qualitative and quantitative studies were included to broaden the perspectives on the CNS role and to meet the review aims.

Exclusion criteria: Studies prior to 1997 and studies not published in English were excluded. Studies in which participants were predominantly based in paediatrics and the community were excluded because they did not meet the inclusion criteria. Midwifery in New Zealand is now direct entry and midwives may not be registered nurses, moreover, pregnancy is not considered an illness/ disease process therefore studies of midwifery CNSs were excluded. Psychiatric CNS studies were also excluded as the context and practice may differ significantly from the acute medical-surgical setting. Studies without explicit methodologies were excluded as the strength and validity of the evidence could not be evaluated. Using the inclusion and exclusion criteria, articles were excluded in three stages. Initially by reviewing the title, then the abstract and lastly by reading the complete article (Meade & Richardson, 1997).

The sample consisted of thirty five research articles all of which were descriptive, and focused primarily on CNS activities, differentiating the CNS role from other nursing roles, describing experiences of CNS role development and demonstrating the effectiveness of the role. Descriptive literature is defined as “having a stated purpose, research question or hypothesis; a literature review, description of methods, presentation and analysis of data, discussion and conclusion” (Sparbel & Anderson, 2000, p.19). Fourteen studies focused on the oncology CNS and three of these specifically focused on the gynaecological oncology CNS.

Data Collection and Extraction

The systematic extraction of data is an essential stage in an integrative review. Data collection instruments included creating a coding sheet formatted for easy extraction of data. To establish the validity and reliability of the coding sheet the Brown, Upchurch & Acton (2003) strategy was used. This process consisted of;

- (a) Reviewing four random studies from the sample selected
- (b) Listing all the relevant coding variables relevant to the research aims
- (c) Incorporating the variables into the coding sheet
- (d) Pilot testing the coding sheet on two further studies

The coding sheet categories included methodological design, study strengths and limitations, demographic data and the variables of interest. The variables identified from a brief review of literature included; twenty nine CNS activities, twenty factors affecting role development and six clinical outcome measures. Each study was systematically read and analysed using the coding sheet to record the data which was entered onto an excel spreadsheet. In this way the data is organised into a matrix which simplified the data synthesis process.

Data were compared item by item and similar data were grouped together in categories. These categories were compared and analysed to identify emerging themes and patterns. Finally, findings were synthesised. Care was taken not to classify the themes from the background reading and pre-empt the findings from the review process.

Findings and Discussion

This integrative review identified 35 relevant studies, comprising of 22 published in the UK, 10 in the USA and 3 in Australia. Of note, no New Zealand studies were identified. A wide range of research designs were utilised and included 16 qualitative, 17 quantitative and 2 mixed method studies. The studies were categorized and from these emerged four themes determined by the main focus of the research:

- 1) Describing the CNS role ($n=7$)
- 2) Differentiating the CNS role ($n= 8$)

3) The role development experiences of CNS ($n=7$)

4) The effectiveness of CNSs ($n=13$).

Table 1 provides an overview of the research purpose, country of origin of each article, research design and the potential strengths and weaknesses of each study.

Table 1: Summary of Research of the CNS Role 1997-2007

Author	Purpose	Country	Method	Potential strengths (+) and limitations (-)
Amir, Scully, & Borrill (2004)	To explore the role of specialist nurses in the breast care team	UK	Grounded theory. Observation and in-depth structured interviews <i>n</i> =16 breast care teams <i>n</i> =24 BCNS <i>n</i> =25 Consultant surgeons <i>n</i> =14 Oncologists <i>n</i> =20 Radiologists <i>n</i> =20 Pathologists <i>n</i> =6 Nurses <i>n</i> =30 Other health professionals	(+) Pilot study (+) Length of field work 45 days (+) Interview schedule (+) Sample size (-) Non random sample (+) Validity addressed (+) Multiple sites
Ball (2005)	To describe advanced/specialist nursing roles, the nurses in the roles, the organisational infrastructure surrounding them in order to map the variety of roles that exist in the UK	UK	Quantitative Postal survey <i>n</i> =507 <i>n</i> =174 CNSs	(+) Questionnaire piloted (+) Sample size (-) Non random sample (+) Response rate
Booth, Beaver, Kitchener, O'Neill & Farrell (2005)	To explore women's experiences of information, psychological distress and worry after treatment for gynaecological cancer	UK	Descriptive Prospective survey and semi-structured interviews at initial diagnosis and 6 months later <i>n</i> =61 <i>n</i> =2 CNS	(+) Two sites (-) Non random sample (+) Variety of instruments (+) Validated tools (-) Study not designed to test CNS intervention (-) Wide variation in time from diagnosis to interview

Bousefield (1997)	To provide a methodical pathway to give recognition and acknowledgement to the personal meaning of the CNS in the 1990s. To define the CNS role in relation to specialist clinical practice	UK	Phenomenology. Interviews open questions <i>n</i> =7	(-) Sampling (+) Cross section of CNS specialities (-) Length of interview and setting not addressed (+) Data analysis method (-) Limitations not addressed
Darmoody (2005)	To describe the work of the CNS in acute care setting using the NACNS model as an organising framework	USA	Descriptive pilot study. Direct observation and time study 5 x4hrs=20hrs over 2 month period <i>n</i> = 5 CNS unit based	(-) Sample size (-) One site (+) Potential Hawthorne effect addressed (+) Organising framework as data collection tool. (+) Conceptual definitions (+) Achieves purpose (+) Limitations acknowledged
De Vito Dabbs, Curran, & Lenz (2000)	To describe the development of a database to describe the practice component of the CNS role	USA	Quantitative Descriptive pilot study over 3 months <i>n</i> = 1 CNS	(+) Validated coding scheme and patient care data set (-) Database not tested (-) Convenience sample (+) Limitations acknowledged
Duffield, Forbes, Fallon, & Roche (2005)	To determine whether there is a differentiation in the roles of CNS and RN by examining the percentage of time spent in 25 specific activities	Australia	Quantitative A work-sampling study conducted over 8 weeks RN's & CNSs	(-) One site (-) Sample size not stated (-) One activity recorded per intervention (+) Validated data collection tool (+) Inter-rater reliability (+) Randomised times for data collection (+)53,240 observations recorded

Dunn, Pretty, Martin, & Grassner (2006)	To explore the major components of Nurse Specialist roles in South Australia and to develop a framework for the description and evaluation of these roles	Australia	Qualitative Illuminative evaluation Focus groups <i>n</i> =30 CNSs	(+) Two study sites (-) Non random sample (+) Focus groups validated data analysis (+) Three focus group meetings
Faithfull, Corner, Meyer, Huddart, & Dearnaley (2001)	To determine if nurse-led care would reduce side-effects and improve quality of life for men undergoing pelvic radiation therapy. To determine if nurse-led care would increase patients' satisfaction and reduce costs.	UK	Randomized controlled trial (RCT) rate <i>n</i> =115 <i>n</i> = 58 CNS group <i>n</i> = 57 control group conventional follow up	(-) No of phone calls of control group not recorded (+) Randomization & stratification of groups (+) Variety of validated tools (+) Hypothesis II supported (+) Response rate
Forbes, While, Dyson, Grocott, & Griffiths (2003)	To identify and synthesis the evidence on the role of clinical nurse specialists in meeting the needs of people with multiple sclerosis.	UK	Systematic review <i>n</i> =33 studies	(+) Criteria defined for advanced nursing roles (+) Tool for critical appraisal of literature (+) Quasi-legal framework for data synthesis (+) Hypothesis supported (+) Validity and rigour addressed
Garvican, Grimsey, Littlejohns, Lowndes & Sacks (1998)	To describe patient satisfaction with a nurse led clinic screening for breast diseases in London and assesses the clinical expertise of the nurses	UK	Quantitative Postal survey <i>n</i> =119 patients <i>n</i> =102 general practitioners	(-) Validity and reliability of questionnaire not addressed (-) Non random sample (-) Lack of published details (+) Sample (+) Response rates

Gibson & Bamford (2001)	To examine the role and development of the CNS	UK	Qualitative Grounded theory Five Focus groups <i>n</i> =25	(+) Sample size (+) Two study sites (+) Questions piloted (+) Validity addressed (-) Sampling method description
Glen & Waddington (1998)	To explore the transition from Staff Nurse to novice Clinical Nurse Specialists	UK	Qualitative Case study research <i>n</i> = 2 CNSs	(+) Combination of data collection methods (+) Theoretical framework (-) Sample size (-) Longitudinal data collection
Glover, Newkirk, Cole, Walker, & Nader (2006)	To use an evidence-based approach to provide recommendations for a delineated role for the perioperative CNS that would provide role clarity and practice guidance	USA	Qualitative Systematic review <i>n</i> =859 articles	(+) Sample size (+) Conceptual framework (+) Search strategy (+) Inter-rater reliability and validity addresses
Hiller (2001)	To identify and compare the Nurse Practitioner and CNS roles in gastroenterology	USA	Cross-sectional comparative descriptive study Postal survey <i>n</i> =10 CNSs <i>n</i> =NPs	(-) Poor response rate (-) Sample size (-) Unequal groups for comparison (-) Nonrandom sample (+) Reliability and validity of tool tested
Knowles, Sherwood, Dunlop, . Dean, Jodrell, McLean, & Preston (2007)	A pilot study to assess the feasibility of a follow-up programme led by nurse specialists for patients with colorectal cancer	UK	Quantitative Prospective pilot study. <i>n</i> =60	(+) Variety of validated tools (+) Adapted questionnaire piloted (-) Nonrandom sample

Jack, Oldham, & Williams (2002)	To evaluate the impact of hospital-based palliative care CNSs	UK	Qualitative, Evaluation study (part of doctoral thesis) <i>n</i> =27 Key stakeholders	(-) One site (-) Short interview (+) One interviewer did all the interviews (-) Nonrandom sample (+) Explicit data collection & analysis
Jefferies (2002)	To assess if the informational and emotional needs of ovarian cancer patients are being met according to their individual requirements	UK	Descriptive Postal Survey <i>n</i> =24 <i>n</i> = 7 women diagnosed before CNS appointed <i>n</i> =17 women diagnosed after CNS appointed	(-) Researcher is the CNS (-) Sample size (+) Questionnaire piloted (-) Nonrandom sample (-) Unequal sized groups for comparison
Lincoln (2000)	To compare the CNS and NP roles to insight into role activities	USA	Descriptive comparative study Postal survey <i>n</i> =130 CNSs <i>n</i> =189 NPs	(+) Random sample (-) Inclusion criteria (+) Sample size. (+) Variety of instrument tools (+) Conceptual framework (+) Content validity addressed (+) Response rate
Lindeke, Canedy, & Kay (1997)	To investigate the similarities and differences between CNS and NP practice domains	USA	Qualitative Semi-structured interviews <i>n</i> =15	(-) Wide variation in time since NP education completed (+) Conceptual framework (+) Trustworthiness of data (-) Nonrandom sample implied

Llahana (2005)	To identify and explore the personal characteristics, attitudes and skills of the CNS and to determine whether the role performance is influenced by these parameters	UK	Quantitative Postal survey . <i>n</i> = 334 Diabetes CNS	(-) Sample Diabetes CNS (+) Sample size (+) theoretical framework (+) Hypothesis tested (+) Content Validity and reliability addressed (+) Pilot study
Loftus & McDowell (2000)	To explore what is important and what is unique in the experience of the oncology clinical nurse specialist (OCNS)	UK	Phenomenological approach Unstructured interviews <i>n</i> =8 CNSs	(-) Convenience sample (+) Five study sites (+) Consensual validation (+) Trustworthiness addressed (+) Interview process pretested (+) Audit trail
Maughan & Clark (2001)	To determine whether a causal relationship exists between quality of life and sexual functioning of women with gynaecological cancer and an intervention provided by a CNS	UK	Mixed methodology approach RCT and inductive qualitative study <i>n</i> =36 100% response rate <i>n</i> = 19 CNS group <i>n</i> = 17 control group	(-) Researcher provides CNS intervention (-) One site (-) Mismatch in groups receiving adjuvant treatment (+) Validated data collection tools (+) Response rate
McCaffrey Boyle (1997)	To provide insight into the issues related to longevity and retention of experienced CNSs	USA	Descriptive study survey- questionnaire <i>n</i> =12 CNSs	(-) Nonrandom sampling implied (-) Non validated tool (-) Limitations not addressed (+) Participants worked as CNS> 10years

McCreadie (2001)	To investigate the current work and role of the clinical nurse specialist	UK	Qualitative Grounded theory Semi-structured interviews <i>n</i> = 20 CNSs	(+) Two sites (-) Sample self identified as CNS (-) Nonrandom sample (-) Pilot interviews (+) Audit trail (+) Trustworthiness addressed
McGee & Castledine (1999)	To develop a contemporary account of the expectations of senior personnel throughout the UK with regards to the roles of the specialist nurses and advanced nurses.	UK	Descriptive Postal survey <i>n</i> = 283 Chief Nurses	(+) Sample size (+) Replication of survey (-) Nonrandom sample implied (-) Rigour & validity not addressed
Moore, Corner, Haviland, Wells, Salmon, Normand, Brada, O'Brien, & Smith (2002)	To assess the effectiveness of nurse led follow up in the management of patients with lung cancer	UK	RCT <i>n</i> = 140 <i>n</i> = 66 medical follow up <i>n</i> = 74 CNS follow up <i>n</i> = 2 CNS <i>n</i> = 140 general practitioners	(+) Sample size (+) randomisation and stratification of participants (+) Four study sites (-) Number of patient deaths during study (+) Validated data collection tools (+) Variety of data collection tools
Moore, Wells, Plant, Fuller, Wright, & Corner (2006)	To describe the preparation and development of a model of nurse led follow-up care, identify key nursing interventions provided within nurse led follow-up care and provide insights into the experiences of nurse specialists providing follow-up care.	UK	Qualitative data embedded in a large RCT and Semi-structured interviews <i>n</i> = 51 Patient case-notes analysed <i>n</i> = 2 CNS <i>n</i> = 2 study coordinators <i>n</i> = 8 team meetings recorded	(-) Embedded data rather than a specific research study (+) Random case notes selected (+) Findings combination of CNS experiences and study co-ordinator observations (-) Trustworthiness or validity not addressed

National Breast Cancer Centre's Specialist Nurse Project Team (2000)	To explore the implementation, acceptability, impact and cost of an evidence-based specialist breast care (SBN) model in diverse Australian settings	Australia	Multicentre demonstration project n=167 Retrospective control group n=133 Telephone interviews Additional data -observational studies, Qualitative structured interviews with HCPs n=47	(+) Four study sites (-) Control group retrospective data (-) Non randomised sample (+ -)Telephone interviews (+) Socio demographic characteristics of control and intervention groups equal (+) Variety of data collection tools (+) Response rate
National Council of State Boards of Nursing (2007)	To delineate the roles of the nurse practitioner and clinical nurse specialist. To provide data to the boards of nursing to assist them in determining the level of regulation appropriate for NPs and CNSs	USA	Quantitative Electronic survey response rate 11% so postal version of survey conducted response rate 30% n = 1,529 NPs n= 1,344 CNSs	(-) Response rate (+) Sample size (-) Non random sample
Seymour et al., (2002)	To examine the understandings and experiences of postholders in relation to the Macmillan Nurse role	UK	Grounded theory. Semi-structured interviews n=44 Macmillan Nurses and n=47 key colleagues	(-) Multiple interviewers (+) Variety of sites (+) Sample size
Scott (1999)	To describe the roles, activities & skills of the clinical nurse specialist in the USA	USA	Descriptive study Postal survey n = 724 CNSs Subscribers to CNS journal	(+) Sample size (+) Questionnaire pretested and used in pilot study twice (-) Purposive sample (+) Theoretical framework (+) Content validity addressed

Sutton et al., (2005)	To determine the impact of a nutrition CNS on the rate of catheter-related sepsis. To analyse the cost-effectiveness of the role	UK	Retrospective and prospective audit of Hickman catheter -related infection rates <i>n</i> =1 CNS	(-) No data on type of patients (+) Longitudinal data (+) Infection defined (-) Nonrandom sample
Wheeler (2000)	To determine whether differences exist between patients with total knee replacement on hospital units with or without CNSs in terms of selected process and outcome	USA	Comparative correlational design Retrospective chart audit <i>n</i> =128 patients, 4 groups with in each <i>n</i> = 32 patients in each group 2 control groups 2 CNS intervention groups	(-) Did not state the intervention CNSs provided (-) retrospective chart audit (+) Random sample (+) sample size (+) Definition of conceptual model (+) Variety of tools (+) Content validity addressed (+) Inter-rater reliability addressed
Wolf (2004)	To explore the experiences of women who has undergone breast reconstruction to understand how they considered their informational needs could be best met.	UK	Qualitative Focus groups <i>n</i> =8	(-) Random sample (-) Retrospective memory recall (-) Small size (-) One site (+) Reliability & consistency confirmed (-) Response rate

The Four Emergent Themes

Theme One: Describing the CNS role.

In the sample seven studies (20%) were focused on describing role components and activities of CNSs. Darmoody (2005) used direct observation to record the work activities of CNSs and the NACNS model of CNS practice as the organising framework. The findings revealed the majority of CNS time was spent in nursing personnel activities. De Vito et al. (2000) conducted a pilot study of a database to identify the CNS clinical practice component and identify patterns and trends about the care they provided. The findings demonstrated two styles of practice pattern: CNSs either followed every patient or only complex, high risk patients within a specialty area. In Dunn et al.'s (2006) exploratory study, focus groups were used to firstly identify and describe key components of nurse specialists (NS) and secondly, to develop an evaluation framework for the role. Amir et al. (2004) explored the role of breast cancer nurses (BCN) and found they were a "pivotal lynchpin" (p.313) in sharing information between team members and had established an informal leadership role within the team. However they had no power outside of the team to enact change. McCreaddie (2001) utilised a grounded theory approach and conducted interviews to investigate the role of CNS, the key component of the CNS role identified was that of 'communicator-carer'. McCreaddie found the close relationship that may develop through assisting patients at times of vulnerability and stress was meaningful for both the CNS and patients. Using role theory to describe the roles, activities, skills, cost-savings and revenue generating activities of

CNSs Scott (1999) found CNSs performed advanced practice skills, spending the most time in the expert clinician role. Administrative activities were increasingly undertaken but only a few CNSs identified cost-saving activities. Llahana (2005) conducted a large postal survey of diabetes CNSs (DSNs) in the UK to explore their characteristics, role components and role development. Llahana identified DSNs had advanced knowledge and specialist skills and spent the majority of time in direct care and the least time in research activities. Moreover, the most frequent research activities undertaken by DSNs were product evaluation and evaluating patient outcomes.

These studies identified the generic CNS role components include clinical expert, educator, consultant, and researcher. Other role components identified included; administration (Darmoody, 2005; Scott, 1999), management and professional development (Dunn et al., 2006), management/leadership, collaboration/ coordination and innovation (Llahana, 2005), change agent (Darmoody), care co-ordinator (De Vito Dabbs et al., 2000), and communicator-carer (McCreddie, 2001). All these studies revealed a different mix of CNS role components. Darmoody suggested the mix of role components may depend on the specialty of the CNS, job description and work setting. What also differed between the studies was the amount of time spent by a CNS in the various components. Llahana identified several factors that influenced the time allocated to each of the role components. These included the job descriptions, work setting

and patient needs, as well as the expectations of the organisation, work colleagues and the CNSs themselves.

Theme Two: Differentiating the CNS from other nursing roles.

Eight studies (23%) were focused on comparing and differentiating the CNS role from other nursing roles. Conducting a large survey of chief nurses in the UK McGee and Castledine (1999) identified specialist nurses (SNs) and advanced nurses (AN) were expected to undertake similar work activities. However, the SN was expected to have in-depth knowledge and skills in a defined area, whereas ANs were expected to practice autonomously across practice settings. Ball (2005), also in the UK, surveyed 506 advanced and specialist nurses but she concluded the roles have similar levels of practice, common core activities with a slightly different mix of activities. Glover et al. (2006) conducted a large systematic review to delineate the peri-operative CNS role by comparing CNSs, NPs and RNs. These authors concluded whereas the NP has a distinct role the CNS role lacks clarity. Glover et al., also claimed the versatility of the CNS role can result in ambiguity in relation to role expectations.

Four studies from the USA compared CNS and NP roles. The NCSBN (2007) commissioned a large survey of NP's and CNS roles to delineate between these roles; they identified the fifteen key activities. Three of the top four key activities were common to both roles, critical thinking and diagnostic reasoning skills in clinical decision making. CNSs rated the activities as most critical functioning in various role components, patient advocacy, functioning

within an interdisciplinary team and utilising evidenced-based research. For NPs the most critical activities were conducting physical examinations, and prescribing and adjusting medications. Lincoln (2000), in a survey of CNSs and NPs, also identified similarities in role functions and components but significant differences in the focus of NP and CNS activities. NPs spent twice as much time as CNSs in direct care whereas the CNS spent time evenly spread between the role components, identifying the consultant as the most important role. Similarly, Lindeke, Canedy and Kay (1997) identified NPs and CNSs had similar role components but there were distinct differences in how the roles were actualised. Furthermore, each role required different knowledge and skills. In a small survey conducted to identify and compare the gastroenterology CNS and NP roles Hillier (2001) reported differences in key role components. NPs identified providing direct care as the key component whereas the CNS identified the educator or consultant as the key component. Hillier found that CNSs and NPs described common characteristics of advanced practice such as “advanced nursing knowledge and skills, advocacy, care coordination and strong research backgrounds as unique APN contributions” (p.243). In contrast, an Australian work-sampling study to differentiate between CNS and registered nurses (RNs) reported CNSs spent the majority of time in managerial tasks and concluded it was unclear if they fulfilled an advanced practice role (Duffield, et al., 2005).

Findings from these seven studies identify the CNS and NP roles overlap but are distinct roles, with the generic CNS role components being clinical expert, educator, consultant and researcher. Other role components

identified included administration (Duffield et al., 2005; Lincoln, 2000; McGee & Castledine, 1999), change agent (McGee & Castledine) and care co-ordinator (Ball, 2005; Glover et al., 2006; Hillier, 2001). The generic role components identified and the wide range of role components supports the findings reported in theme one.

Theme Three: Role development experiences of CNSs.

Seven studies (20%) focused on understanding how CNSs experience their role and identified factors that affected role development.

Using a case study approach to explore the transition of two staff nurses to novice CNSs Glen and Waddington (1998) found the nurses experienced high levels of stress and frustration as a result of lack of role clarity and expectations. They also encountered resistance to change from nursing and medical staff. Seymour et al. (2002) also reported tension and conflicting role expectations between CNSs and managers. Additional sources of conflict reported included a lack of mentorship especially when new to the role and lack of institutional support to pursue educational opportunities. Bousefield (1997) conducted a phenomenological study and found isolation, poor time management, inter/intra role conflicts and lack of support as factors inhibiting role development. Conversely support was also identified as a facilitator for the role to be effective and to survive. McCaffrey Boyle (1997) surveyed twelve experienced CNSs to gain insight into their longevity in the role where they had been for more than ten years. Ten characteristics

were seen to be essential for the success of the role including; nurturing team relationships, confidence in one's expertise and understanding how "organisational variables" may impact on the role (p.1170).

In Moore et al. (2006) the experiences of CNSs developing and establishing CNS follow-up clinics for people with lung cancer identified it took time for the CNSs to feel comfortable in the role despite having a cancer nursing degree, a three month period working alongside medical consultants, and receiving clinical supervision. These CNSs described much of their learning as experiential and they gained confidence through learning new ways of working. Nevertheless it took time for the CNSs to become 'credible' and earn the respect of their colleagues. Furthermore, these CNSs reported they provided patient-centred care that included being "available to patients" (p.515) but were unprepared for the intensity of the nurse-patient relationship that developed. Paradoxically, this relationship was seen as source of emotional burden and job satisfaction by CNSs.

Utilising focus groups to clarify and further develop the CNS role Gibson and Bamford (2001) found CNSs enjoyed the autonomy of organizing their daily work. They experienced varying levels of organisational support and peer support which was extremely helpful, but lacked mentorship, which hindered role development. A key finding from this study was that in order for the full potential of the role to be realised, further structure around the role was required and role development reflecting career progression was necessary. Loftus and McDowell's (2000) phenomenological study of oncology CNSs described the close relationship

that developed with patients was at times viewed as an emotional burden and being on “uncertain ground” in regards to truth-telling (p.515). These CNSs reported utilising reflective practice contributed to developing expertise and the ability to manage nurse-patient boundaries. All of these studies identified many factors that influenced the development and embedding of the role such as organisational, team and peer support, clinical supervision, preparation and mentorship for the role, reflective practice, relational practice and personal characteristics of the CNS.

Theme Four: The effectiveness of the CNS role.

Thirteen studies (37%) focused on the effectiveness of a CNS role. Two randomised controlled trials (RCT) demonstrated nurse-led care was safe, acceptable and cost effective (Faithfull, Corner, Meyer, Huddart & Dearnaley, 2001; Moore et al., 2002). Similarly, Knowles et al (2007) in a pilot study reported CNS follow-up in the management of colorectal cancer was safe, efficient and cost effective. Patients also valued the care co-ordination and continuity of care provided by CNSs. Three studies reported the cost effectiveness of the CNS role incorporating reduced hospital admissions (Forbes, While, Dyson, Grocott & Griffiths, 2003; Wheeler, 2000), length of hospital stay and complication rates (Sutton, Garcea, Pollard, Berry & Dennison, 2005; Wheeler).

Garvican, Grimsey, Littlejohns, Lowndes and Sacks (1998) conducted a postal survey and reported women attending a CNS-led breast screening clinic experienced high levels of satisfaction with the standard of care. The

referring general practitioners (GPs) reported reasons for utilising the service were the high standard of care and requests from women. Furthermore, the analysis of fine needle aspirations taken by CNSs demonstrated a lower percentage of inadequate samples compared to other team members. An Australian multicentre implementation study examined the impact of an evidence-based specialist breast cancer nurse (SBN) model of care. Findings revealed SBNs had a positive impact on women with breast cancer, improved team functioning, appropriate utilisation of each professional skills and improved service delivery (National Breast Cancer Centre's Specialist Breast Nurse Project, 2003). In another study Wolf (2004) conducted focus group discussions with women who underwent breast reconstruction for cancer. The women described the breast care nurses (BCNs) being easily accessible and found the frequent contact was 'invaluable'. The BCNs also provided continuity of care, acting as a link between consultants and different services.

Booth, Beaver, Kitchener, O'Neill and Farrell (2005) utilised a prospective survey and interviews to explore women's experiences of information, psychological distress and worry after treatment for gynaecological cancer. The authors found levels of anxiety, depression and distress improved in women seen by a CNS. Maughan and Clark's (2001) mixed methodology approach included a RCT and open interviews and demonstrated women with a gynaecological cancer who received emotional and informational support from a CNS had improved sexual functioning and quality of life. Jefferies (2002) identified in a survey of women with ovarian

cancer that it was more beneficial to receive information from both the CNS and consultant. In Jack, Oldham and Williams (2002) evaluation study of a CNS hospital-based palliative care service, key stakeholders described the CNSs had an invaluable impact by improving symptom control and in the provision of psychological care to both patients and families. These thirteen studies revealed different ways in which positive aspects of CNS care are perceived by patients and stakeholders, such as, the valuing of nurse-patient relationship, improved quality of life and symptom control, improved service delivery and cost-effectiveness.

Discussion

No universal definition of a CNS was identified in these studies and what was revealed was the complexity in defining this role. The discussion of the integrative review will be guided by the four research questions.

1. What are the generic role components of an acute care CNS?

Findings indicate there are four generic role components of an acute care CNS, clinical expert, educator, consultant and researcher which is consistent with some CNS literature (Gibson, 1999; Murphy-Ende, 2002; Smales & Varia, 2004; Werner, 2005). These four components reflect an early model of the CNS role, whereas a contemporary CNS role includes a fifth component of administrator or management/change agent (Sechrist & Berlin, 1998; Sparacino, 2005) however, this review did not identify this role

consistently as the fifth component. Instead care coordination was identified as a fifth role component (Ball, 2005; De Vito Dabbs et al., 2000; Dunn et al., 2006; Forbes et al, 2003; Glover et al., 2006; Hillier, 2001; Moore et al., 2002; National Breast Cancer Centre's Specialist Project Team, 2003; RCN, 2003). Armstrong (1999) argues that the CNS role components will vary according to the model favoured, organisational needs, patient needs, as well as the goals and job description of a CNS. The emergence of the care coordinator role reflects the evolving nature of the CNS role in order to meet the needs of patients and changes in healthcare delivery.

Darmoody (2005) utilised the National Association of Clinical Nurse Specialists model of CNS practice as a conceptual framework. This model CNS practice actualises within three interacting spheres of influence; patients, nurses and nursing practice, and organisational (Spross & Lawson, 2005). Each sphere has defined competencies and expected outcomes. Darmoody argues this approach integrates CNS practice with a focus on patient-centred care rather than separating practice into role components. Zuzelo (2003) agrees when role components are used to describe practice it is difficult to differentiate between CNS and NP roles. Furthermore, Zuzelo argues the NACNS model offers a broader view of the concept of CNS practice as opposed to the reductionist approach of dividing the role into components.

The degree to which a CNS fulfils all the role components depends on several factors including; the knowledge and experience of the CNS (Castledine, 2002b; Gibson & Bamford, 2001), context of the CNS practice

(Gibson & Bamford; Llahana, 2005; Morrison, 2000) and CNSs individual interpretation of the role. Allen (2003) argues that in order to provide patient-centred care it is essential to integrate all the CNS role components and Beauman (2006), Bousfield (1997), Hill (2000), Llahana, Sechrist and Berlin, (1998) agree to influence and improve nursing practice integration of all the role components is necessary rather than focusing on the clinical practice component.

Nevertheless Sparacino (2005) sees expert clinical practice as central to the CNS role, as advanced skills and knowledge in the provision of direct and indirect care to patients with complex needs is crucial. (Armstrong, 1999; Ball, 2005; Dunn et al., 2006; Hillier, 2001; Moore et al, 2002; Moore et al., 2006; NCSBN, 2007; Scott, 1999; Sparacino, 2005). Some studies revealed that clinical practice was not the foremost role component. In these studies, other activities were seen as the major focus of the CNS role such as: consultant (Hillier, 2001; Lincoln, 2000), educator (Hillier), management (Duffield et al., 2005) and nursing personnel activities (Darmoody, 2005).

Brown (2005) argues a key trait of advanced practice is clinical reasoning based on the integration of experiential and theoretical knowledge. Only two studies identified CNSs utilise clinical reasoning skills and critical thinking in clinical decision making (Dunn et al.2006; NCSBN, 2007). Several studies though implied CNSs utilised these skills in decision making (Ball, 2005; Faithfull et al., 2001; Garvican et al., 1998; Hillier, 2001; Llahana, 2005; Moore et al., 2002; Scott, 1999). Other studies did not explicitly identify these skills perhaps because they are 'assumed' as

characteristics of advanced practice. Autonomous practice is also argued to be a cornerstone of advanced nursing practice. Autonomy was both explicit (Ball, 2005; Bousefield, 1997; Dunn et al.; Hillier; NCSBN; Scott) and implicit in CNS practice within this review (Lindeke et al., 1997; McCaffrey Boyle, 1997; Moore, et al., 2006).

Findings revealed that CNSs practice at an advanced level although some authors suggested CNSs do not practice at the same level, especially when new to the role (Ball, 2005; Gibson & Bamford, 2001; Glen & Waddington, 1998; Llahana, 2005; McCaffrey Boyle, 1997). A key issue related to this is ensuring competency to undertake the CNS role. Several authors have suggested a clinical career structure for CNSs, that required evidence of their competency to practice at an advanced level could stimulate CNSs to maintain professional growth (Finnie & Wilson, 2003; Gibson, 1999; Gibson & Bamford; Walker, 2005) and realise the full potential of the role (Gibson & Bamford; Llahana).

II. What are the activities and skills of a generic CNS role relevant to a gynaecological oncology CNS?

Findings of this review demonstrated there is a paucity of research on the gynaecological oncology CNS role. This specific role incorporates the five generic roles identified above as well key activities required to meet the specific needs of women with a gynaecological cancer. Key activities undertaken by a gynaecological oncology CNS are the provision of informational, emotional and psychosexual support related to the diagnosis,

treatment and management of the sequelae of gynaecological cancer (Booth et al., 2005; Jeffries, 2002; Maughan & Clark, 2001). Gibson and Bamford (2001) suggest the uniqueness of the CNS role results from the way in which specialist skills and knowledge are applied. These studies demonstrated this role can benefit women, and is well placed to provide continuity of care that facilitates seamless cancer care (Maughan, 2003).

III. *What are the factors that affect the development of a CNS role?*

Factors affecting the development of CNSs included some common themes, such as lack of clear role definitions and role expectations, and inconsistent job descriptions which resulted in role confusion and ambiguity (Gibson & Bamford, 2001; Glover et al., 2006; Llahana, 2005). For some CNSs this lack of clarity and role definition may be welcomed as it presents the opportunity for them to interpret and define their role. A lack of mentorship for new CNSs, formalised support and supervision can all contribute to role ambiguity and conflicts (Cox & Ahluwalia 2000; Seymour et al., 2002) and resultant role confusion. Cattini and Knowles (1999), Gibson and Bamford, and Moore et al. (2006) suggest that peer support, mentorship and 'training posts' may assist CNSs to adjust to the role.

Organisational support in the form of necessary resources and understanding of the role was reported as a facilitator of CNS role development, performance and effectiveness (Llahana, 2005; McCaffrey Boyle, 1997). Conversely a lack of organisational support and understanding of the CNS role impeded development of the role. Furthermore, role conflict

and tensions could arise when the expectations of CNS and management differ (Seymour et al., 2002) especially in instances where the CNS is more qualified than their line manager (Bousefield, 1997). To minimise resistance (Kaur, 2003) and for the role to be successful, it was essential for CNS and key stakeholders to have a clear definition and understanding of their role in order in order to set realistic and achievable goals (Bryant-Lukosius, & DiCenso, 2004; Glover et al., 2006; Llahana; Seymour et al.).

IV. *How does a CNS impact on patient care?*

The impact of the CNS role on patient care was demonstrated in a range of improved patient outcomes and service delivery. This included improved symptom control and quality of life, as well as improved efficiency, service delivery and cost-effectiveness. CNS follow-up clinics were identified as successful models of collaborative care rather than CNS-alone care (Faithfull et al., 2001; Knowles et al., 2007; Moore et al., 2002). Patients valued continuity of care provided by CNSs (Ball, 2005; Booth et al., 2005; Dunn et al., 2006; Faithfull et al.; Forbes et al., 2003; Garvican et al., 1998; Knowles et al.; Moore et al.). Saultz (2003) suggests continuity of care is composed of “a hierarchy of three dimensions informational, longitudinal and interpersonal continuity” (p.134) and that interpersonal continuity is typified by a relationship with a clinician based on trust, understanding and respect. Another instance of CNSs providing continuity of care is when junior doctors change and evidence suggests this is valued by patients particularly when there are many doctors involved in their care (Castledine, 2002b; Hill, 2000;

Moore et al., Raja-Jones, 2002). However, Faithfull and Hunt (2005) state in order to provide this level of care CNSs need the skills and confidence to do so.

A key aspect demonstrated in many of the studies that contributed to the 'success' of the CNS role appears to be the relational practice of CNSs (Booth et al., 2005; Forbes et al., 2003; Loftus & McDowell, 2000; McCreddie, 2001; Moore et al., 2006; National Breast Cancer Centre's Project Team, 2003; Seymour et al., 2002). According to Doane & Varcoe, (2005) relational practice encompasses nursing relationships with patients and professional relationships with other health care workers. Moreover, nursing relationships are influenced by the socio-political context of health care and the personal values and assumptions of the individual nurse. Forbes et al. (2003) suggest the benefit of the nurse-relationship is often hidden or assumed in the way the role is evaluated. Measuring many of the activities of a CNS presents difficulties as many are 'hidden' such as acting as a role model and patient advocate (Edmunds 1992, as cited in Scott, 1999), good practice (Gibson & Bamford, 2001), coaching and guiding patients (Spross, 2005), as well as supporting staff (Amir et al., 2004) and patients (Jefferies, 2002). Furthermore, Cutts (1999) argues from a feminist perspective that the notion of 'care' may be devalued in a paternalistic healthcare setting.

Gaps identified in this integrative review include any substantive evaluation of the cultural safety and ethical decision making aspects of CNS practice. This may be because the focus of the studies was not on

illuminating these aspects of CNS practice or that these aspects were assumed to be integral components of CNS practice.

This review identified a wide range of research methodologies were used to study the work and experiences of a CNS. No universal definition of a CNS role was used in the studies. Many of the authors acknowledged the generalisability of the studies was limited by the sample size and context of the CNS. All of the authors recommended future research was warranted to validate the findings, to determine the effectiveness of the CNS in regards to patient outcomes and cost effectiveness and to add to the body of knowledge of the CNS role and to demonstrate the worth of the role.

Limitations of the research

Limitations of this integrative review include the lack of New Zealand research on the CNS role which may limit the generalisability of the findings to the NZ context. One of the difficulties undertaking this research has been deciding what data and literature to exclude. Whilst the sample size is not an adequate basis on which to draw substantive conclusions, the research has delineated some helpful patterns, and insights which have been synthesised into common elements regarding the CNS role.

Conclusion

This chapter has analysed and synthesised selected research related to the CNS role. The findings of this integrative review enabled four research questions to be explored. Firstly, the generic CNS role components of clinical expert, researcher, educator and consultant were identified and found to be consistent with the components described in literature (Dyson, 1997; Gibson, 1999; Werner, 2005). An additional key role of care-coordinator was also identified. This multi-focal nature of the CNS reflects the diversity and complexity inherent in defining this role.

Secondly, findings revealed the gynaecological oncology CNS role incorporates the five generic roles identified above as well as key activities of providing informational, emotional and psychosexual support. Evidence suggests this support may improve sexual and quality of life in women with a gynaecological cancer.

Thirdly, a range of factors were identified that could impact both negatively and positively on the development of the CNS role. Organisational structures, multidisciplinary team and peer support for the role, role preparation and role clarity were amongst these. Strategies used by CNSs to implement and develop their role included fostering professional relationships, clinical supervision and reflection.

Lastly, the impact of the CNS role was demonstrated in patient satisfaction with CNS-led care, the value patients placed on the relational practice of CNSs, improved symptom control and quality of life. The impact

of the CNS role at an organisational level was demonstrated by reduced hospital admissions, reduced length of stay and reduced complication rates and improved service delivery.

This chapter has provided a basis for the final chapter in which the implications of this integrative review for practice will be discussed and some recommendations are made for a gynaecological oncology CNS role. Opportunities and challenges for the development of the role in New Zealand are identified and suggestions for future research will be outlined.

CHAPTER THREE: IMPLICATIONS FOR PRACTICE OPPORTUNITIES AND CHALLENGES

In this chapter the findings of the integrative review and the implications for practice are considered in order to explicate the role of a gynaecological oncology CNS role in New Zealand. The development of a generic and specific CNS role in New Zealand offers opportunities and challenges for nursing to consider which will be outlined before future research topics are suggested.

Cancer was the leading cause of death in New Zealand in 2004 accounting for 28.4 percent of all deaths and cancer registrations of 19,223 were recorded, an increase of 21.2 percent since 1995 (MOH, 2004a). A focus of government health initiatives in New Zealand is improving cancer care throughout the cancer continuum. The need to have a knowledgeable and skilled oncology nursing workforce is recognised as essential to achieving improved cancer care. Kent et al. (2007) reported the rapid increase in oncology nursing speciality knowledge and increasing complexity of cancer care. They identified existing CNS roles in haematology, palliative care, breast and colorectal cancer, there is one palliative care NP but as yet no oncology NPs.

Best practice recognises that informational and emotional support are key components of cancer care (Ferrell, Smith, Cullinane, & Melancon, 2003; Fitch, 2003; Jeffries, 2002; Moore et al., 2002; Scott, 2007; Veronesi et al., 1999). A large proportion of advanced and specialist nursing roles in the UK are the in oncology and palliative care specialties (Ball, 2005). This is a result of political pressure to improve cancer services because of recognition of the increasing complexity of cancer treatments and a greater recognition of the psychosocial and informational needs of cancer patients. As a consequence the role of tumour-specific CNSs has emerged (Hill, 2000).

Gynaecological cancers involve a diverse group of diseases and collectively are the fourth most common cancer in women in NZ (MOH, 2004a). Cancer of the cervix, uterus and ovary are among the most common cancers in Maori women (MOH, 2005b). The incidence of cervical cancer in Maori women is twice that of non-Maori and Maori women are four times more likely to die from cervical cancer than non-Maori (MOH, 2004a). Pacific women also have a relatively high rate of cervical cancer and not enough Pacific and Maori women are having regular cervical screening. To reduce cervical cancer registrations and deaths in Maori women, it is essential to increase the uptake of cancer screening programmes through improving accessibility and enhancing the responsiveness of cancer services to the needs of Maori and Pacific women (MOH, 2005b).

The diagnosis, treatment and post treatment sequelae of gynaecological cancer can impact on all aspects of a women's life (Allen,

2003). Women may need to cope with a wide range of issues including loss of fertility, self-confidence, self-esteem, altered sexuality and body image (Bourgeois-Law & Lotocki, 1999; Hawighorst-Knapstein et al., 2004; Juraskova et al., 2003). Evidence shows that most women are unlikely to use vaginal dilators as recommended post radiotherapy treatment for gynaecological cancer, unless they receive education and assistance to overcome fears (Juraskova et al.). Research demonstrates a gynaecological oncology CNS can improve the quality of life of women through the provision of psychosocial support and information (Allen; Booth et al., 2005; Corner, 2003; Cohen et al., 2002; Jeffries, 2002; Maughan, 2003; Maughan & Clarke, 2001). Hill (2000) argues that cancer site-specific CNSs currently have a large clinical workload and this may increase with the chronicity of many cancers, hence the need to make transparent the role of the gynaecological oncology CNS.

Implications for Practice

The following discussion is based on my interpretation of the findings from the integrative review, relevant literature and personal reflection on the gynaecological oncology CNS role in New Zealand. Given Hill (2000) the following discussion will incorporate the identified five generic role components of clinical expert, educator, consultant, researcher and care coordinator. Interwoven throughout the discussion will be an emphasis on the unique roles of a gynaecological oncology CNS as identified by Allen (2003) that of, providing psychosocial, psychosexual and informational

support and communicator, in order to explicate how a gynaecological oncology CNS role could evolve within the context of the five identified generic role components.

Clinical Expert

The literature emphasises that the CNS is an expert clinician who utilises advanced skills and knowledge (Ball, 2005; Bousfield, 1997; Hillier, 2001; Llahana, 2005; Scott, 1999; Sparacino, 2005) to provide direct and indirect care in order to improve patient outcomes (Rose et al., 2003). Through the regular provision of direct care a CNS maintains clinical expertise and gains credibility with medical and nursing staff (Bousefield, 1997; Sparacino). Acting as a role model CNSs demonstrate advanced skills and mentor other nurses to improve nursing practice (Allen, 2003; De Vito Dabbs et al., 2000; Footner, 1998; Moore, 2005; Sparacino).

The following bullet points underneath each of the five role components are based on the literature from the integrative review. These key points could form the baseline for a CNS in gynaecological oncology.

The Gynaecological Oncology CNS:

- Requires substantial theoretical and experiential knowledge in cancer care (RCN, 2003), pathophysiology including but not limited to: carcinogenesis, cancer genetics, co-morbidities associated with ageing, gynaecological physiology, physiological affects of surgery

and the principles of surgical, medical and radiation oncology treatment for gynaecological cancer.

- Is able to conduct comprehensive physical assessments (Bousefield, 1997; Footner, 1998; Henderson, 2004; Knowles et al., 2007; Moore et al., 2002; Scott, 1999) demonstrating clinical reasoning skills (Dunn et al., 2006;) to develop, implement and evaluate a nursing care plan based on assessment data (NCSBN, 2007).
- Is able to interpret laboratory investigations, radiology reports and histopathology reports (Knowles, et al., 2007; Moore, 2005; Scott, 1999) and utilises clinical reasoning skills to integrate data as part of comprehensive assessments (Dunn et al., 2006; Moore et al., 2002; NCSBN, 2007).
- Is able to apply the above knowledge and skills to provide expert direct care (Scott, 1999) to women with gynaecological cancer throughout the cancer continuum (Cancer Nurses Society of Australia [CNSA], n.d.).
- Utilises validated assessment tools to monitor and manage treatment related sequelae (CNSA, n.d.).
- Provides indirect care by offering support and supervision to nursing staff in planning, assessing and evaluating nursing interventions (Johnson & Yarbrow, 2000; Smales & Varia, 2004).
- Demonstrates and role models the integration of the principles of the Treaty of Waitangi, that of partnership, protection and participation in

clinical practice (NCNZ, 2007; NZNO, 2000). Promotes culturally competent care and utilises strategies to enhance cultural awareness in other staff (Jeffreys, 2005; NCSBN, 2007; Rose et al., 2003) and enhance responsiveness to meet the needs of others.

- Utilises advanced knowledge and skills to be an advocate for women and families (Amir et al., 2004; Darmoody, 2005; Hillier, 2001; Jack et al., 2002; Montgomery & Steinke, 2006; NCSBN, 2007; Sparacino, 2005; Whittemore, 2000; Wolf, 2004).
- Anticipates ethical dilemmas and helps to clarify issues to ensure the best outcomes for patients and staff. Demonstrates advanced ethical decision making skills, role models these skills in discussions with patients about treatment choices (NCSBN, 2007; Sparacino, 2005).
- Is able to conduct a holistic psychosocial assessment of the informational, emotional and practical needs of patients and families (Amir et al., 2004) and provides psychological and psychosocial support to patients and families (Knowles et al., 2007; Loftus & McDowell, 2001; Maughan & Clarke, 2001; Moore et al., 2002; National Breast Cancer Centre's Specialist Breast Cancer Project Team, 2003).
- Demonstrates elements of clinical and professional leadership at a nursing and organisational level and utilises change theory to effect innovative change to improve patient outcomes (Amir et al., 2004; Bousefield, 1997; Darmoody, 2005; Footner, 1998; NCSBN, 2007; Scott, 1999; Sparacino, 2005; Zuzelo, 2003).

Educator

The CNS provides education and shares her expert knowledge and skills with patients and families, nursing staff and the multidisciplinary team (Allen, 2003; Armstrong, 1999; Scott, 1999). This incorporates formal and informal activities (Sparacino, 2005) including; providing in-service ward teachings, teaching and mentoring nurses, one-to-one, teaching on study days, cancer courses and presenting at both national and international conferences. Spross (2005) argues coaching patients through illness transitions is a complex process. Moreover this aspect of the CNS role is often invisible and difficult to quantify. The nurse-patient relationship is pivotal to successfully guiding patients and requires expert interpersonal skills. Evidence suggests a lack of information is a source of anxiety and distress for people with cancer and a significant proportion of people find it difficult to process information, make decisions and follow complex treatment regimes (Turner et al., 2005). Women need to feel comfortable to discuss psychosexual issues and it is important they are given the opportunity and time to discuss them (Allen; Amir et al., 2004; Maughan & Clarke, 2001). Maughan and Clarke state it is essential gynaecological oncology CNSs should undergo formal education in psychosexual interventions. Patients may face uncertainty and anxiety often throughout the cancer continuum and clarifying what is happening can decrease the level of anxiety (Faithful & Hunt, 2005).

The Gynaecological Oncology CNS:

- Provides formal and informal education to patients and families, nursing staff, junior medical staff, the multidisciplinary team and the wider community (Allen, 2005; Johnson & Yarbrow, 2000; Montgomery & Steinke, 2006; Scott, 1999).
- Is able to assess the educational needs of staff and provides learning opportunities to meet the needs of staff (Darmoody, 2005; Footner, 1998; Lincoln, 2000; McCreaddie, 2001; Montgomery & Steinke, 2006).
- Creates a supportive environment that encourages staff to examine and reflect upon their practice and acts as a role model and mentors nursing staff (Dunn et al., 2006; LaSala et al., 2007; NCSBN, 2007; Scott, 1999; Sparacino, 2005).
- Provides information to help patients and families understand the cancer process, treatment options and potential side effects to ensure informed consent (Dunn et al., 2006; Faithful et al., 2001; Moore et al., 2002; Moore, 2005) and reduce anxiety (Faithful & Hunt, 2005).
- Develops implements and evaluates educational resources for patients and families (Dunn et al., 2006; NCSBN, 2007; Scott, 1999; Sparacino, 2005).
- Is able to conduct a psychosexual assessment to identify patient concerns or informational needs (CNSA, n.d.; Maughan & Clarke,

2001) and identify patients who require intensive psychosexual therapy (Shell, 2002).

- Utilises best practice guidelines to educate women on the use of vaginal dilators post vaginal brachytherapy (National Forum of Oncology Nurses, 2005).
- Provides education and information to the community (NCSBN, 2007) to raise awareness of gynaecologic cancers.
- Develops a personal and professional practice development plan (Cattini & Knowles, 1999; Kaur, 2003). It is essential CNSs continue their own continuing professional development to maintain their advanced knowledge and skills (Bousefield, 1997; Johnson & Yarbrow, 2000; Sparacino, 2005).
- Disseminates specialist knowledge and skills at local, national and international conferences (Darmood, 2005; NCSBN, 2007).

Consultant

The CNS acts as a consultant to patients, families, nurses, other CNSs, medical staff and the multidisciplinary team and is often seen as a source of specialist information to assist with problem solving (Amir et al., 2004). In a seamless health care system they can provide specialist advice to generalist district nurses and oncology nurses (CNSA, n.d.). At an organisational level CNSs may consult with nurse managers to develop policies, protocols and standards of care (Moore, 2005). At a national level

CNSs may contribute to healthcare policy (Henderson, 2004). CNSs may also collaborate with non- government agencies such as the Cancer Society to improve the outcomes for women with gynaecological cancer and families.

The Gynaecological Oncology CNS:

- Works in partnership to ensure patients gain the knowledge and services they require to maintain independence and to maximise their coping strategies (National Breast Cancer Centre's Specialist Breast Cancer Project Team, 2003; NCSBN, 2007).
- Demonstrates advanced interpersonal communication skills (LaSala et al., 2007; Scott, 2007; Spross, 2005; Zuzelo, 2003).
- Is recognised as a source of specialist information by nurses, patients and families and provides expert clinical advice to assist with problem solving (Amir et al., 2004).
- Acts as an internal and external consultant to nursing staff, patients and family, medical and allied health staff, and the community (Johnson & Yarbrow, 2000; NCSBN, 2007; Smales & Varia, 2004).
- Collaborates with non- government agencies such as the Cancer Society to ensure patients and family members have community supports to meet informational, emotional and practical needs.
- Participates in local and national health policy-making related to gynaecological oncology (Sparacino, 2005).

Researcher

The aim of CNSs is to improve patient outcomes and nursing practice. An essential component of the CNS role is to utilise research to inform and change practice (Armstrong, 1999; Sparacino 2005; Moore, 2005). A CNS involved in direct care needs to possess research skills to help answer questions generated from clinical practice this seeks to link current evidence, theory and practice.

The Gynaecological Oncology CNS:

- Is able to evaluate current research, disseminate and utilises research findings in their own practice (Armstrong, 1999; Footner, 1998; Morrison, 2000; Johnson & Yarbro, 2000; McCreddie, 2001; Moore, 2005; NCSBN, 2007; Scott, 1999; Sparacino, 2005).
- Fosters an evidence-based philosophy of care through questioning practice, undertaking literature searches, developing and writing protocols (Morrison, 2000; Zuzelo, 2003).
- Is able to initiate and conduct research (Footner, 1998; McCreddie, 2001; NCSBN, 2007) as well as collaborate with other nurses, medical staff and multidisciplinary team members in research activities (Dunn et al., 2006; Lincoln, 2000; Moore, 2005; Rose et al., 2003; Scott, 1999; Sparacino, 2005).
- Develops and implements best practice standards (Montgomery & Steinke, 2006; NCSBN, 2007; Rose, Ali & Gresham, 2003).

- Evaluates own practice to demonstrate patient outcomes in line with professional and organisational goals (Sparacino, 2005), the Cancer Control Strategy (MOH, 2003) and Cancer Control Action Plan 2005-2010 (MOH, 2005a, 2005b).
- Accurately records CNS activities which enable CNS practice trends to be tracked over time and the effectiveness of practice to be evaluated (De Vito Dabbs et al., 2000; Dunn et al., 2006; Sparacino, 2005).

Care coordinator

Care coordination means ensuring the cancer care experience for women is as seamless as possible so that they do not get lost in the system (Moore, 2002) and receive fragmented care. Women with gynaecological cancer often have complex service coordination needs. Many women may require shared-care that is receiving care concurrently from different health care professionals or services in different geographical areas. The CNS develops relationships with the multidisciplinary team, and external healthcare providers to ensure a seamless transition from hospital to the community. The CNS engages with patients to build a relationship and provides continuity of care (Knowles et al., 2007). This constancy facilitates patients accessing the CNS when assistance or information is needed (Moore et al., 2002).

The Gynaecological oncology CNS:

- Is able to gain an understanding of the needs of women through engaging with women and families (Whittemore, 2000) and being available (Knowles, et al., 2007; Moore et al., 2006; Wolf, 2004) knowing (Loftus & McDowell, 2001, McCreaddie, 2001; Moore et al., 2006).
- Demonstrates advanced understanding and skills in relational practice (Doane & Varcoe, 2005).
- Coordinates interdisciplinary collaboration (Amir et al., 2004; Darmoody, 2005; Rose, Ali & Gresham, 2003; Sparacino, 2005) to ensure discharge plans and resources are in place prior to discharge.
- Demonstrates the ability to cross organisational boundaries (Kitson, 1999; Knowles et al., 2007) to facilitate a seamless journey for women.
- Collaborates to ensure continuity of care and acts as a link between patients, consultants and services to ensure consistency of information and information sharing between services (Amir et al., 2004; Knowles, et al., 2007; Moore et al., 2002; National Breast Cancer Centre's Specialist Breast Cancer Project Team, 2003).
- Models communication and collaboration skills to other staff to foster team cohesiveness (Sparacino, 2005).

- Provides coordination between hospitals, primary care, community services and palliative care to ensure a seamless patient service (Kitson, 1999).
- Undertakes patient satisfaction surveys to ensure effective patient outcomes (Scott, 2007).

In this section the integrative review findings have been the basis for outlining the role of a gynaecological oncology CNS. Recommendations have also been suggested for this role. In the following section the findings of the review are applied to the generic CNS role in New Zealand.

The Development of the Generic CNS Role in New Zealand

This integrative review identified a range of barriers to developing the CNS role. Included were a lack of clearly defined roles, inconsistent job descriptions and inconsistent role expectations, all of which lead to ambiguity and confusion especially when new to the role (Gibson & Bamford, 2001; Glover et al., 2006; Jones, 2005; Llahana, 2005). In order to realise the full potential of a CNS and maximise improved patient outcomes the introduction and embedding of these roles require strategic planning to minimise resistance (Kaur, 2003), rather than, haphazard role development to meet service needs. Bryant- Lukosius and DiCenso (2004) and Gardner et al. (2007) describe models for the implementation and evaluation of advanced practice roles.

A framework entitled “the participatory, evidence-based, patient-centred process, for an APN role development, implementation and evaluation (PEPPA)” was developed to address the unique challenges associated with APN role development (Bryant-Lukosius & Dicenso, 2004, p. 531). The underlying principle and strength of this framework is the patient-focus. A number of planning and strategic steps are included, one of which is involving key stakeholders early in the process to identify shared-goals, which in turn promotes understanding of the role. This goal orientated and outcome-based process involves ongoing monitoring of the role.

Building on the earlier work of Mick and Ackerman (2000) Gardner et al. (2007) believed the ‘Strong Model of Advanced Practice’ provided a sound and rational model for the implementation of advanced practice roles that remain within the RN scope of practice such as the CNS role. The model describes five service parameters of an APN role as direct comprehensive care, support of systems, education, research and publication and professional leadership Gardner et al. that suggest are useful to differentiate between APN and NP roles. Gardner et al. argued an operational framework to identify, implement and evaluate advanced nursing roles is required to ensure new roles meet health care needs and improve patient outcomes.

Currently in New Zealand there are no national standards or competencies for the CNS role. The ongoing debate in the literature reflects the difficulty defining and differentiating the CNS from other advanced nursing roles. Daly and Carnwell (2003) argue that clear frameworks and

competencies for advanced nursing roles are essential to prevent roles evolving haphazardly. They suggest a framework that reflects levels of practice and autonomy would help differentiate between roles. At an international Advanced Nursing Practice conference in Singapore, Phillips (2005) signalled a growing debate that a NP with a narrow scope of practice could constitute a CNS role. At the recent NCNZ Forum (2007) two NP presentations focused on advanced practice nursing roles in New Zealand. Forde (2007) highlighted that the differentiation between the CNS and NP is not as evident as in other countries because NPs in New Zealand can practice within a narrow scope of practice. Harris (2007) suggested NPs, CNSs and specialty nurses have common domains of practice but differentiation between the roles is reflected in the level at which each role is practiced and all are context driven. Harris also acknowledged some roles will fluctuate between the three levels.

Kent et al. (2007) adapted the RCN (2003) cancer specialist nursing pathway to the New Zealand context to suggest a pathway to advanced practice roles in cancer nursing. The NP pathway is an established accreditation process that requires applicants to have a Masters degree and a portfolio demonstrating advanced nursing competencies (NCNZ, 2001). The challenge for the nursing profession is to develop a framework and pathway for other advanced nursing roles within the New Zealand context.

The Republic Of Ireland adopted a national approach to the development and implementation of advanced nursing practice roles establishing the National Council for the Professional Development of

Nursing and Midwifery (NCNM) independent of the An Bord Altranais, the nursing regulatory board (NCNM, 2007). A local, regional and national approach to the development of new positions has been implemented. The clinical career pathway has been developed includes three levels, these being generalist, specialist and advanced practice. Frameworks for the establishment of CNS and advanced nurse practitioner (ANP) positions have been developed and resources are available to healthcare organisations to identify the service need for a new position. Definition of roles and generic job descriptions are available. Healthcare providers must apply to the NCNM for approval to introduce new advanced nursing roles and the nurse then must present evidence to be accredited to the CNS or ANP role. This national approach ensures consistency in titles, job descriptions and competency assurance and as such has much to offer New Zealand as both countries have public healthcare systems and similar sized populations.

A clinical career ladder for CNSs was introduced in an Australian hospital to promote excellence in clinical practice, recognise and financially reward individuals for continued professional development (Walker, 2005). The framework has three successive levels and the competencies for each level require the applicant to demonstrate increasing depth of knowledge and experience. Every CNS is expected to submit their portfolio of evidence on appointment and annually at performance appraisal. This framework resembles the PDRP process in New Zealand and may offer a useful framework for consideration.

Currently designated roles are not included within PDRP however, a nationally consistent PDRP process could offer benefits to a CNS, employers and the public of New Zealand. These include national recognition of the CNS role, this could stimulate ongoing professional growth in the role as well as the opportunity for career progression, and offer an incentive to remain in the role. Employers could be assured CNSs are competent to practice at the level for which they are employed and the public would have the assurance that the CNS has the advanced clinical skills, knowledge and seniority the title implies. To develop this certain changes would need to occur. Firstly, NCNZ would need to develop competencies for CNSs. Secondly, the primary aim of a PDRP process for CNSs could be to demonstrate competency for the role and secondly recognition for professional development this should therefore be mandatory. A national review process rather than local peer review would facilitate an impartial and robust process as the number of CNSs in smaller DHBs maybe too few to be impartial. Competency-based accreditation would strengthen the role, provide clarity for nurses, provide protection for the public, and for employers through ensuring CNSs have the knowledge and skills to practice at the level for which they are employed. Bousfield (1997) claimed the challenge for the CNS was to “preserve, protect and promote the role of the clinical nurse specialist” (p. 254) and I would argue ten years later this still is the major challenge facing the CNS role.

Opportunities for Future Research

The demand for healthcare in New Zealand is projected to increase driven by an ageing population, the increasing incidence and chronicity of cancer, cardiovascular disease, obesity, and diabetes (MOH, 2000). The growing consumer demand for a high quality service in these complex areas, along with reflection on the CNS role suggests a place for a RN with expertise at an advanced level. The role of the CNS is pivotal to meeting the healthcare challenges in the 21st century. Crucial to the CNSs ability to respond to increased population healthcare needs is a clearly defined role, scope of practice and set of competencies. The challenge for the NCNZ is to respond to the Ministerial Taskforce (MOH, 1998) recommendations to recognise and develop CNS competencies.

Litchfield (2002) argued for a framework for advanced practice based on New Zealand research and a decade later the pivotal issue of consensus on the competencies and scope of practice for advanced practice roles other than the NP is still be reached. Conducting future research on role development of CNSs in the New Zealand context will increase the body of knowledge on this evolving role and continue to provide evidence for practice. Undertaking this integrative review has highlighted a lack of research on the CNS role in New Zealand. The formal description and evaluation of CNS roles is an essential prerequisite to determine competencies and an operational framework for the role.

To measure the effectiveness of advanced practice roles Dyson (1997) suggested job descriptions should be outcome-based. The difficulty is

to capture the 'art' or the creative dimension of nursing, as well as the more easily measured outcomes. Diverse research designs will be required to try and capture the full scope of the work of a CNS. Research on the role and experiences of CNSs in New Zealand could provide evidence of the ways in which the role is actualised and the level at which CNSs practice. This could provide the basis for job descriptions, the development of evidence-based competencies and a clinical pathway for CNSs as well as differentiate the CNS from other roles.

In summary, this chapter offered recommendations for a gynaecological oncology CNS role which will provide guidance for my practice. Strategic planning models have been identified which could help to overcome some of the barriers to the development and implementation of this crucial role. Forde (2007) and Harris (2007) presented initial frameworks to distinguish between advanced nursing roles in New Zealand. The challenge now facing the profession is to develop a clear career pathway for advanced practice roles other than the NP role. Opportunities for future research have been suggested that would build evidence for practice and demonstrate the impact of this role on patient outcomes.

Conclusion

In an effort to explicate an evolving gynaecological oncology CNS role this dissertation has explored the generic CNS role. This exploration has revealed the complexity and diversity that not only characterises the CNS role, but has also identified the factors that contribute to the difficulty in defining this advanced practice role. This study supports Christensen's (1999) view that the CNS should be Masters prepared and focused on a population with specific health needs. Although I have not addressed substantively the educational preparation required for the CNS, the findings of this dissertation suggest that a Masters degree is required to fulfil the identified key role components.

The generic role components identified in the integrative review of clinical expert, educator, consultant, researcher and care coordinator are key skills utilised by a gynaecological oncology CNS in addition to providing informational, emotional and psychosexual support. Other research indicates that the RN working in a CNS role can help women with a gynaecological cancer improve their quality of life and sexual functioning. The relational practice of a CNS demonstrated as integral to improved patient outcomes and service delivery.

Many factors identified impacted on the development of the CNS. Strategic planning involving key stakeholders could overcome many of the identified barriers that so often hinder the successful development, implementation, and embedding of a CNS role. The development of competency-based assessment for advanced nursing roles other than the

NP would provide clarity for nurses and employers, and provide assurance for the public that nurses have the necessary knowledge and skills. Indeed the improved service delivery and improved patient outcomes identified by the Ministerial Taskforce (MOH, 1998) would be achieved if the evolution of this crucial role is supported.

My challenge at the beginning of this dissertation was to explore and consider the contribution of the CNS role with a view to further developing my role as gynaecological oncology CNS. This study has convinced me of the importance of all CNS's being able to describe and articulate their practice and the importance of practice based research that demonstrates the significance of this leadership role. This topic is of such interest and complexity that it warrants further study, debate and discussion.

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Appendix 1

This Position Description is a guide and will vary from time to time and between services and/or units to meet changing service need March 2005

POSITION TITLE:	Gynaecology/Oncology Nurse Specialist	
	Gynaecology Ward	
REPORTS TO (Title):	Service Manager, Gynaecology Services	
	Charge Nurse, Gynaecology Ward	
REPORTS ON A DAILY BASIS TO:	Charge Nurse, Gynaecology Ward	
PRINCIPAL OBJECTIVES		
1. The Gynaecology/Oncology Clinical Nurse Specialist provides clinical leadership for nursing practice and acts as a resource person for nurses and others working in the Gynae Ward other health care facilities and the community.		
2. Demonstrates and actively promotes expert clinical practice and the provision of quality post-operative care which supports the focus of the Gynaecology/Oncology service.		
3. The Gynaecology/Oncology Clinical Nurse Specialist promotes nursing excellence to achieve 'best practice' outcomes in the Gynaecology Ward and is a clinical expert, demonstrating this in their practice.		
4. In liaison with the Clinical Charge Nurse of the Gynaecology Ward and the Gynaecology Nurse Educator, the Gynaecology/Oncology Nurse Specialist will develop and implement a framework for ongoing inservice education		
FUNCTIONAL RELATIONSHIPS:		
INTERNALLY:		
EXTERNALLY:		
1	Director of Nursing,	As required with patients and their families
2	Gynaecology Service Manager,	General Practitioners
3	Charge Nurses,	Referral Sources and suppliers and other agencies
4	Nursing and Medical Personnel,	Cancer Society
5	Multidisciplinary Team,	Palliative Care Service
6	Gynaecology Nurse Educator,	
7	Patients and their families	
8	Radiology	
9	Outpatients Department	
10	Oncology Department	
KEY PERFORMANCE OBJECTIVES:		

Task	The Gynaecology/Oncology Nurse specialist provides clinical leadership within the Gynaecology Ward
Expected Result	<p>1.1 Provide leadership in nursing practice and be actively involved in the supervision, encouragement and monitoring of nursing practice in the Ward, in consultation with the Charge Nurse.</p> <p>1.2 Retain clinical expertise within the specialty and demonstrate this in practice.</p> <p>1.3 Actively participate in reviewing and developing new guidelines, policies and procedures, on consultation with other members of the interdisciplinary team.</p> <p>Promote “best practice” and critical evaluation of patient outcomes within a supportive environment.</p>
Task	The organisation and co-ordination of patient care within the Gynaecology Ward.
Expected result	<p>2.1 In conjunction with the Charge Nurse of the Gynaecology Ward, implement nursing practice quality nursing care and policies and procedures.</p> <p>2.2 Ensure patient’s safety and privacy and cultural needs are met.</p> <p>2.3 Participate in the Gynaecology/Oncology Multidisciplinary Team Meeting to ensure a team approach to patient outcomes and planning of discharge.</p> <p>2.4 Liaise with radiology and pathology regarding scheduling of investigations so that they are undertaken within a timely manner and available for the Gynaecology clinic.</p> <p>2.5 Develop a communication strategy with the Oncology Department to ensure that relevant information is shared between the services in a timely manner thus ensuring the scheduling of patients for following investigations, treatments and Outpatient appointments.</p> <p>2.6 Develop and document agreed referral practices to external agencies that provides a smooth pathway for patients e.g. Palliative Care Team</p> <p>2.7 Ensure referrals to other health professionals are initiated in a timely manner.</p> <p>2.8 Co-ordinate all investigations and consultations with other services so that these are available for review at Gynaecology/Oncology clinics.</p>

Task	Promotes research based practice within the Gynaecology Ward.
Expected Result	<p>3.1 Apply new nursing knowledge in practice and disseminates this, as appropriate.</p> <p>3.2 Evaluate current research findings for speciality, including the development of clinical pathways and discharge planning.</p> <p>3.3 In consultation with the Charge Nurse and Service Manager, use critical incidents as an opportunity for staff development and reflective practice.</p> <p>3.4 Attends educational opportunities, specialty meetings, relevant to the role and scope of practice.</p> <p>3.5 Reflects own practice using critical incidents as a learning experience.</p>
Task	In consultation with the Gynaecology Ward Charge Nurse, facilitates staff and unit development.
Expected Result	<p>4.1 To organise the orientation of new staff to Gynaecology/Oncology nursing practice, ensuring they are supported by ongoing planned education, in conjunction with the Gynaecology Ward Charge Nurse and Gynaecology Nurse Educator.</p> <p>4.2 In conjunction with the Gynaecology Ward Charge Nurse and Gynaecology Nurse Educator develop and implement an inservice plan to meet the needs of the Unit.</p> <p>4.3 Utilise formal and informal opportunities for staff development/-education.</p> <p>4.4 Utilise appropriate strategies to bring about changes in practice where indicated.</p> <p>4.5 Develop resource materials, self-learning packages and teaching aids for the area.</p>
Task	Responsible for maintaining and communicating relevant information.
Expected Result	<p>5.1 To establish and maintain effective lines of communication with all members of the Gynaecology Ward.</p> <p>5.2 To communicate information in a timely and relevant manner.</p> <p>5.3 To ensure nursing documentation identifies, plans sensitive to situation and environment, patient/family involvement, teaching information.</p>
Task	To assist with development and scheduling of Gynaecology/Oncology clinics.

Expected Result	<p>6.1 Co-ordinate all investigations and tests that need to occur prior to the clinic assessment.</p> <p>6.2 Liaise with Outpatients Department on scheduling and timetable of clinics.</p> <p>6.3 Liaise with the relevant Gynaecology/Oncology surgeons on cases that need further investigation, consultation and communicate this plan with the patient.</p> <p>6.4 Ensure that every patient seen at the clinic has a follow up plan after their 3/12 visit and they are aware of how this will occur and by whom ie specialist, G.P, phone call, follow up appointment.</p>
Task	To ensure relevant data is collected and available for a department audit.
Expected Result	<p>7.1 Develop and maintain a register of Gynaecology/Oncology patients to ensure patients continue their follow-up plan eg. phone each patient annually, provide support, letter to specialist or file of symptoms</p> <p>7.2 Develop and participate in department activities which monitor/audit delivery of quality patient care, eg. accreditation processes, current or retrospective audits.</p>
Task	The Gynaecology/Oncology Nurse Specialist is responsible for further developing his/her own levels of personal and professional development.
Expected Result	<p>8.1 Demonstrates a commitment to self-development, which is congruent with the needs of the Gynaecology Ward.</p> <p>8.2 In conjunction with the Charge Nurse, set performance objectives and goals which will be reviewed as part of the appraisal process.</p> <p>8.3 In liaison with the Charge Nurse and Service Manager, identify and attend educational opportunities and speciality meetings that are relevant to the role and scope of practice.</p>
Task	The Gynaecology/Oncology Specialist will undertake other duties as reasonably directed by the Charge Nurse and Service Manager of the area.
Expected Result	<p>9.1 Complete all duties in a professional and timely manner and in the best interests of the Division</p>

HEALTH & SAFETY:

Implement or lead and implement emergency procedures and maintain a safe and secure work environment by following relevant DHB and Divisional policies, protocols and standards. This includes but is not limited to:

- Practice safe work habits and ensure the health and safety of yourself and others
- Make unsafe work situations safe or, inform a supervisor or manager
- Is knowledgeable about hazards in the work area and the procedures in place to identify and control hazards
- Use Personal Protective Equipment correctly and when required
- Report hazards, incidents, accidents, and near misses promptly and accurately
- Seek advice from manager if unsure of work practices
- Complete mandatory training as required
- Is knowledgeable of emergency procedures and evacuation plans
- Assists in maintenance of equipment as required, and reports faulty equipment promptly
- Actively practice clinical standard precautions

QUALITY:

Every staff member within the DHB is responsible for ensuring a quality service is provided in their area of expertise. All staff are to be involved in quality activities and should identify areas of improvement. All staff are to be familiar with and apply the appropriate organisational and divisional policies and procedures.

QUALIFICATIONS & EXPERIENCE:**Essential**

- The Gynaecology/Oncology Clinical Nurse Specialist should be registered with the New Zealand Nursing Council of New Zealand as a Comprehensive or Registered General/Obstetric Nurse.
- Hold a current Nursing Council of New Zealand practising certificate.

Desirable

- Demonstrate a commitment to staff development and research based practice.
- Hold validated clinical expertise in the specific area.
- Validate his/her expertise by working towards post registration/academic qualifications relevant to the role.
- Possess expert clinical assessment skills.
- Be an acknowledged leader within the defined speciality.
- Demonstrate the ability to contribute to the professional development of nursing throughout the organisation.
- Provide leadership within nursing.
- Demonstrate a commitment to staff development and research based practice.

PERSONAL ATTRIBUTES:

PERSON SPECIFICATION

- Have a proven ability to support nursing staff at all levels of practice.
- Have excellent communication skills and the ability to communicate across all interdisciplinary groups.
- Have excellent administrative, organisational and time management skills.
- Have the ability to accommodate and initiate.

LIMITATION ON AUTHORITY

Matters which must be referred to the Charge Nurse/Service Manager

- ⇒ Staff requirements in excess of agreed staff levels.
- ⇒ Security breaches
- ⇒ Incidents relating to patients or staff well being
- ⇒ Staff performance, which may lead to disciplinary action.
- ⇒ Quality standards failures or deficiencies.
- ⇒ Any matters which do not comply with District Health Board's Policies and Procedures.
- ⇒ Any concerns of a clinical nature.

The intent of this position description is to provide a representative summary of the major duties and responsibilities performed by staff in this job classification. Staff members may be requested to perform job related tasks other than those specified.

Appendix 2

Clinical Nurse Specialist Job Descriptions

	Specialty	Education	Expert Clinical practice	Quality Improvement	Leadership	Education	Research	Health & safety	Management	interpersonal skills/ communication	Other duties as directed
1	Wound Care-DN	BN- & Masters or willing to do masters		√		√		√			
2	Generic	Has or willing to do masters	√	√	√	√		√			
2a	Gynae-Onc CNS	Working towards post registration qualification	√	√	√	√				√	
3	Cadiac Nurse Specialist	Has or working towards Masters	√	√	√	√	√	√		√	
4	CNS- Mental Health	Masters or working towards	√					√		√	
5	Wound-CNS	BN /Eligible for Masters	√	√	√	√	√	√			
6	CNS- Palliative Care	RN- Desirable- BN/masters	√	√		√			√	√	
7	Diabetes Nurse Specialist	Not Stated	√	√	√	√	√			√	
8	CNS- Cardiology	Post grad Cert/dDip				√	√	√			√
9	Generic CNS	BN/ Post grad Dip- or work towards + Portfolio demonstrating advanced nurse competencies	√	√	√	√	√	√			Consultant & Change Agent

